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Clinical Ethics Consultations and the Necessity of NOT Meeting Expectations: I Never Promised You a Rose Garden

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Abstract
Clinical ethics consultants (CECs) work in complex environments ripe with multiple types of expectations. Significantly, some are due to the perspectives of professional colleagues and the patients and families with whom CECs consult and concern how CECs can, do, or should function, thus adding to the moral complexity faced by CECs in those particular circumstances. We outline six such common expectations: Ethics Police, Ethics Equalizer, Ethics Superhero, Ethics Expediter, Ethics Healer or Ameliorator, and, finally, Ethics Expert. Framed by examples of requests for ethics consultation that illustrate each kind, along with brief descriptions, we argue that while these expectations ought to be resisted for clear and practical reasons, they also create opportunities for CECs to articulate, educate, and ultimately be responsible to the professional demands of clinical ethics work. Recognizing, acknowledging, and at times resisting those expectations thus become key activities and responsibilities in the performance of ethics consultation.

Keywords Clinical ethics consultation · Professional expectation · Professional responsibility

Introduction

Great expectations often abound in the fields and disciplines that comprise contemporary healthcare contexts. There are clinically rooted expectations from patients, families, and healthcare providers—which often arise from the hopes, fears, and

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experiences individuals bring with them into the clinical context; there are administrative expectations—by which healthcare professionals are evaluated (and pay allocated and adjusted); there are institutional expectations—on which clinical services are ranked and compared; and there are multiple other kinds of aspirational and baseline expectations framing what is acceptable in terms of professional behaviors, interactions, and outcomes. In professional settings, moreover, as in many other settings, even if expectations are not clearly defined or articulated, they can be deeply held and influential. When such expectations are not met, they can create confusion and disappointment at the least, and breaches of trust and anger at the worst: if someone is expecting a rose garden but finds themselves in a vegetable patch, even the most bountiful growth of vegetables is going to be a let-down.

The field of clinical ethics is no exception and hence is not immune from such expectation. Indeed, the question about meeting expectation is being deeply rooted in the earliest days of clinical ethics (White et al., 2018), and recognizing, acknowledging, articulating, and responding to expectations have been taken to be a key activity—and responsibility—in clinical ethics consultation given the ways expectations add layers to the moral complexity faced by ethics consultants in any particular circumstance and context (Agich, 2005; Barnard, 1992; Bliton & Finder, 2002, 2010).This may well explain why over the past 20 years concerns about expectations have occasionally risen to a fever-pitch, especially in the context of credentialing, certification, and other aspects of professionalization (Andereck et al., 2012; Aulisio et al., 2000; Dubler et al., 2009; Fins et al., 2016; Kodish et al., 2013). What is clear is that clinical ethics consultants work in complex environments where multiple types of expectations emerge about their roles and responsibilities as well as about the particular activities in which they are (or are not) to engage for fulfilling such expectations (Bliton & Finder, 1999, 2002; Frolic, 2011; Zaner, 1984, 1988)—all of which often practically leads to those working in clinical ethics encountering the question of whether their services are valued by others (Gaucher et al., 2013; Tarzian, 2013).

Typically, within the context of such questioning about expectations, the idea has been put forth that striving to meet expectations is a good thing. In what follows, however, we will suggest something slightly different: to be responsible in the practices and activities constituting clinical ethics consultation, ethics consultants may be obligated at times to not meet, and even *to resist,* the expectations of healthcare colleagues, patients and families, administrators, or even some peers in the field of clinical ethics. Our insistence upon resistance is rooted in a particular frame for expectations, namely, that expectations ought to be understood, and hence approached and addressed, in terms of the work actually done in the real contexts where clinical ethics consultation is enacted.

Explicit Expectations About Articles: Practice for Peer-Learning

In an article that proposes greater attention, engagement with, and even resistance to some of the expectations people carry about clinical ethics consultation work, it behooves us to begin by naming and clarifying some expectations related to what

we are about to present and explore. To that end, in what follows we do not intend to offer a detailed analysis of every possible expectation around clinical ethics practice that one might encounter in the midst of doing actual clinical ethics work, let alone the sources of meaning and value such expectations carry. To do so would require a much larger body of work (a series of articles at the minimum, if not a series of books!). Instead, the aim of this article is to name and briefly describe what we, in our own practice, have frequently encountered, and to use these as a launching pad for some general exploration of their significance.

Moreover, rather than begin with the presumption that all who participate in the performance of clinical ethics consultation share clearly established and deeply held expectations about clinical ethics, we begin not merely with the premise that there are many expectations swirling around every consultative encounter but also that considering how—and why—different types of expectations might emerge in a given clinical ethics encounter is a crucial part of a clinical ethics consultant's responsibility—and a way of generating conversation and peer learning in the field (Finder & Bliton, 2018).

As such, we further begin with an understanding that, akin to how ethics consultants need to discover the various values at stake in a given clinical situation and not merely presume them (Zaner, 1994a), ethics consultants cannot presume to know what those others with whom the consultant interacts actually understand about Clinical Ethics and clinical ethics practice before a consultation begins—this too needs to be discovered (Finder & Bartlett, 2017). Even with well-established, well-publicized, frequently consulted ethics consultation services, to presume that an ethics consultant's practice (and self-understanding of that practice) lines up with the requestor's expectations or the expectations of the other individuals with whom the ethics consultant will interact, or that whatever the ethics consultant expects to do or have happen in whatever subsequently unfolds, mirrors those others' expectations is a set-up for misunderstanding at best, and significant conflict at worse (Bartlett et al., 2016). Hence, we begin our exploration of expectations with an understanding of them as a subterranean but essential starting point for the practice of clinical ethics itself—and of any well-informed Bioethics practice more broadly.

Accordingly, in this article we aim to surface and identify examples of layered expectations—even in broad form—as practice for doing so in actual consultation conversations. Moreover, we are doing so as part of a peer-to-peer practice because *our expectation* is that the expectations around clinical ethics work will continually evolve and change—in the institutions where we work, in our self-understanding as a field of peers and colleagues, and as a field of public Bioethics professionals—especially in the current moment in which Bioethics has gained a new prominence in the face of the COVID-19 pandemic. Thus, rather than expect that we all know and share an understanding of what to expect, we believe it necessary to openly engage in discourse about what expectations we all might encounter, and whether these are matters to embrace, resist, or even use to reframe what may be at stake as part of actual clinical ethics practices and institutional service.

We are, thus, cognizant of a number of pertinent questions that are already emerging and demanding of attention even before we explicitly turn to the main substantive focus of this article: How do any of the expectation examples described below,

which are reflective of *our* particular clinical ethics practice, fit with the experiences of others who provide ethics consultation? What questions do these expectations raise for us – as Bioethics professionals – about our work, about needs and opportunities for engaging education and communication in our local environments, about mentoring our trainees, and teaching our students? Moreover, what do possible answers to the prior question imply about how we might enter into any given ethics consultation—and as we carry our own expectations into those beginnings, what must be done in order to best ensure that we still hear and respond to the expectations of those others with whom we interact? And perhaps most significantly, and running counter to the various expectations we have tried to outline here as crucial for what follows, if we *can and should expect shared understanding* about what it is we do when doing clinical ethics work, what is the basis for *that* expectation? And finally, how do we (or even, *should we?*) examine our *own* expectations about our work—individually, with immediate clinical ethics colleagues, with immediate non-ethics colleagues, patients, and others with whom we interact in specific clinical ethics encounters, and finally, as professional peers and as a field?

All of the above frames what follows below. As a result, the aim of what follows is to share themes and patterns we have encountered in our clinical ethics experiences, as well as some questions and reflections they have raised, *as an example* and *as an invitation* whereby, in response, readers too might identify, clarify, and articulate their thoughts, experiences, and reflections on their own practices. Both the ASBH Core Competencies and the HCEC-Certification process assure that local diversity is recognized and valued (ASBH, 2011; Horner et al., 2020). Hence, just as carrots love tomatoes and the different plants grow stronger together, we hope there is space for overlap, connection, consideration, and peer-learning. This may not be a rose garden we are offering, but we are inviting readers to get down in the nitty–gritty dirt, together, to see if we can get something growing with each other.

Brief Preface on the Structure of What Follows

As described previously, the exploration of expectations as they are clinically presented is a core starting point for our practice of clinical ethics consultation. But this is not a *prima facie* stance; after 40+years and despite having presence in diverse kinds of clinical contexts, publications and presentations, educational efforts, and outreach within the various institutions and communities in which clinical ethics has been practiced—especially over the past two decades – there continues to be good grounds for thinking that the field and practice of clinical ethics is still far from unified and singularly understood (Courtwright & Jurchak, 2016; Guerin et al., 2020; Yoon et al., 2020). As such, and reiterating a point already noted, even those with whom ethics consultants work closely over time may not fully know what to expect regarding the role of ethics consultation or of the actual work of ethics consultants. What follows are thus illustrations of six common expectations those with whom we interact often bring to ethics consultations, or articulate when they encounter us *qua* "ethics consultant." These expectations reflect both what we have gathered from our own clinical encounters and experiences and what may be found within the clinical ethics

literature; indeed, some version or another of the expectations we experience daily are noted in the literature from the earliest days of the field (Annas, 1984; Churchill, 1978; Churchill & Cross, 1986; Fleetwood et al., 1989; La Puma & Toulmin, 1989; Siegler & Singer, 1988; Skeel & Self, 1989; Spicker & Sushner, 1989; Zaner, 1984).

To help in these illustrations, each presentation of the various "kind" of expectation begins with several verbatims from actual requests for clinical ethics consultation we have received; these verbatims reflect, and have helped us elucidate, that "kind." These verbatims are drawn from what literally was said in requests for ethics consultations we received from nurses, residents and attending physicians, from family members and allied health professionals, and from all areas of our medical center – adult and pediatric, Intensive Care Units (ICUs) and general non-ICU units, from chronic as well as acute situations.[1] After the verbatim examples, we offer a very brief discussion of challenges raised by the particular kind of expectation being illustrated. This is followed by critical reflections on the expectation under consideration. In all cases, even if the expectations presented are not wholly original to us, it is our experience of them that serves as the primary impetus for what follows. Following these six illustrations, we turn explicitly toward our rationales for responding to and resisting expectations.

The Six "kinds" of Expectations (summary overview)

Ethics Police

The surgeon is trying to convince patient to agree to a procedure. Patient is refusing procedure (with family support). However, surgeon is continuing to push for this surgery and has ordered the nursing team to not feed the patient and continue blood draws – this is distressing the nurses as there is no surgery scheduled for this patient and they feel this is "unethical".

How can they practice medicine like that?"

I'm taking care of a 70-year-old male newly diagnosed with lymphoma, with an advance directive and POLST [Physician Order for Life-Sustaining Treatment] that stated he did not want to be intubated or have chemotherapy. Well, the patient was admitted to MICU [Medical Intensive Care Unit] yesterday intubated and started on chemotherapy in spite of being "Do Not Resuscitate." The patient's DPOA [Durable Power of Attorney] who is NOT a family member allowed the oncology team to start chemotherapy on this pt. What good are advanced directives and POLSTs if we don't honor patients' rights???? I'm notifying you to make sure this is not ignored.

Can't someone do something about this patient's son?

[1] These requests came to us mostly by phone, although in some cases they were sent as emails. For those received via phone call, we attempt to write what callers actually say, although sometimes we merely summarize the main gist. Because they contain no identifying information and were not collected as part of human subjects research, our local IRB leadership advised no need for IRB approval or exemption.

One of the most common and persistent expectations is that ethics consultants are Ethics Police (Smith & Weise, 2007)—and thus the perspective that the role of the ethics consultant is to "protect and serve" the innocent or the victimized as well as "enforce" that the right thing is done. Expectations that the clinical ethics consultant can and should serve as a protector or enforcer are often rooted in notions that clear and self-evident rules exist that delineate what is right and what is wrong, and that these are known widely and are clearly applicable in actual clinical contexts. These notions about "ethics rules," and hence a need for the Ethics Police, persist in a variety of medical and healthcare settings despite – or perhaps sometimes even because of – the daily experience of clinical complexity, variability, and uncertainty, and a wish for some sense of justice and fairness and of reliable knowledge about what to do in a difficult circumstance.

That said, aside from the sheer, unfettered hubris it would take to accept the mantle of Ethics Police, there is the simple and practical problem that if our colleagues think we are some kind of enforcer, acting as judge and jury (and possibly executioner) regarding ethical behavior, they may well, ironically, become hesitant to reach out, even in (or perhaps especially in) the most dire and distressing of circumstances. The reason for this is fairly uncomplicated: bringing into the clinical context someone seen as having this kind of enforcement power can, and often does—sometimes only temporarily, other times long-lasting – cause significant disruptions in relationships with colleagues, with patients, and with patients' families; such disruptions, moreover, may denude the requestor's own standing as a clinician and hence their ability to provide care (especially if they may subsequently be seen as having broken confidences, of "telling tales out of school," and undercutting trust). In addition, their use of ethics consultation as a form of policing may well alter their own subsequent interactions with ethics consultants insofar as they may begin to see the consultant as potentially coming after *them* next.

For patients and families too, construing the ethics consultant as police amplifies the experience of clinical encounters as adversarial encounters; while it may well be that their experience of their interactions with the physicians and nurses who are to be taking care of them *is* adversarial, the notion of the ethics consultant as one who sorts people into those requiring protection and those subject to punishment actually only serves to reinforce legalistic, adversarial views of clinical care – and healthcare providers, patients and families, and ethicists alike have railed against that conception of the clinical encounter for 30 years or more (Pellegrino & Thomasma, 1988, 203–6; Smith & Weise, 2007). Finally, the idea of ethics consultants as Ethics Police reinforces notions of ethics as black and white, concrete and immutable – which has almost no relation to the complexities and variability of ethical issues and moral experiences encountered in healthcare contexts (Zaner, 1988). The risk for the ethics consultant who self-understands their role as that of Ethics Police is thus to lose sight of, and access to, what may actually be at stake in the fine-grained nuance of an actual clinical encounter (including, ironically, that those whose situation it primarily is may well be seeing, and having problematic consequences as a result, clinical relationships as primarily adversarial).

Ethics Equalizer

> *If she wasn't a big donor, the doctors would never be doing all this and she wouldn't be allowed to treat the staff the way she does…*
>
> *It's just not fair—this family keeps protesting, saying the patient will die if he goes home, and they make a stink and threaten to sue and so their dad will stay here until he dies… but when my grandmother was here 3 months ago, we wanted her to stay here while she was dying, but they made us leave, go to a SNF [Skilled Nursing Facility]…and I work here!*

Stemming from a concern for justice and fairness, we get calls from colleagues who expect us to make sure that one patient is not treated any differently than another. This expectation is often framed as a concern that all patients receive the same treatments or level of care, and every patient, family, and care providers are similarly treated the same—and in all cases, treatment and interactions are to be done irrespective of race, gender, religion, ethnicity, education, or socio-economic/VIP status, and so on. As with the idea of the ethics consultant as the Ethics Police, this expectation has been identified by others (Alfandre et al., 2014; Fromme et al., 2008). What demands attention regarding the clinical expression of this expectation is that often implicit in this expectation is that "treated the same" means that different patients will receive the same interventions or have the same outcome; anything else is seen as "less" and hence as evidence that *someone* is not treating every patient as they should. Or, conversely, this reflects the belief that certain clinicians are seen to get extra consideration or privileges—or to "get away with" otherwise unacceptable behaviors because of their rank, their income-generating value, or their personalities. Such perceived disparity among clinicians especially is taken to be another source of "injustice" and unfairness. In both circumstances, such inequality is seen as clearly "unethical," hence the frequent overlap of the expectations that the ethics consultant should be Ethics Equalizer as well as Ethics Police. There often emerges consensus in such circumstances among the clinical teams that something is *just not fair* and the ethics consultant should be the one to *do something* about such injustice—presumably thanks to decades of locating justice as one of the four primary principles of biomedical ethics (Beauchamp & Childress, 2019).

Given such complexities and variability of moral experiences within clinical contexts, the problem with being an Ethics Equalizer is that not all things *are* ethically equal and not everyone *should* get the exact same treatments or interventions. The idea of blind justice is practically inaccurate for clinical care *qua* clinical; indeed, even in our legal system the idea of such simplistic equality is recognized as inaccurate (Pager, 2005). As well, clinical experience continually demonstrates that *context* matters: different outcomes based on differences in the clinical circumstances are the norm, not the exception—and the challenge is emphasizing that equality in clinical care (including clinical ethics) is about orientation and striving to meet each patient's unique needs, not assuring each

patient receives exactly the same kind or amount of an intervention as the next patient. Equity, not equality, is the operative principle.

Similarly, when questions of fairness are about hierarchy, privilege and behaviors, the ethics consultant's role and involvement can be an occasion for identifying shared and institutional expectations, creating space for, and supporting those looking for, institutional resources and responses, including education that the ethics consultant cannot—and should not—compel or enforce others' behavior. Equalization, then, only makes sense as a process rule, not an outcome nor a power. In this sense, to be seen as—by others or oneself—as an Ethics Equalizer is to misconstrue fundamental notions about the sources of what might lead to fair and fitting treatment.

Ethics Superhero

> *Team seeking assistance from Ethics to communicate with family regarding appropriate plan of care.*
>
> *Physician requesting that an Ethics Consultation be ordered to evaluate patient's plan of treatment (gastro tube placement?).*
>
> *Social Worker requesting clinical ethics meeting with patient's family to discuss code status and goals. Primary physician seems uninterested in discussing code status with family.*
>
> *We need someone to come in from the outside and help us resolve this mess…*

The ethics consultant who is to be the Ethics Superhero is the one who will, so to speak, "save the day," often by communicating – with family, other care providers, across services, up chains of command, and so on—when others cannot or do not do so. In this sense, the ethics consultant is taken to be a "fixer" or "problem solver" for intractable circumstances and seems to emerge out of the concern of various stakeholders, although most usually clinicians, regarding their own responsibility: "I have tried (or for some reason am unable to try) to resolve the situation—I feel powerless—so someone else surely can come onto the scene and make things right." And the notion that the "someone else" ought to be the ethics consultant (or the process of ethics consultation) has been embraced and promoted not only by stakeholders but also by some in the field, looking to promote ethics consultation as a valuable service within institutions (Crico et al., 2020).

Much like the issues making the notion of an Ethics Equalizer problematic, the expectations associated with being the Ethics Superhero serve as an endorsement that it is acceptable for others to avoid their own responsibilities. In our efforts to be helpful and in our efforts to demonstrate value, clearly articulating the role of, and specifically the limits of, clinical ethics consultation may be necessary, even if initially unwelcome. After all, the ethics consultant is not responsible for changing a code status—that is a medical order for which the physician is responsible, no matter how much the physician wishes the ethics consultant would just have that conversation in their place. Nor should the ethics consultant's first inclination be to speak to a physician on behalf of a nurse who is feeling disempowered—to do so

only reinforces the power imbalance. In other words, accepting the Ethics Superhero expectation and working to meet it runs the risk of creating or endorsing learned helplessness—and overstepping the ethics consultant's own responsibilities and activities. Finally, in putting on that mantle when the patient or family request it, the ethics consultant may very well undercut the necessary lines of trust and communication between patient and care provider which are essential for healthcare to be adequately delivered.

Ethics Expediter

> *Patient refusing to leave hospital without Dilaudid PCA [Patient-controlled analgesia pump] and will not go to a Hospice. Need Ethics help.*
>
> *Physician requesting ethics consultation to hopefully assist in determining safe & appropriate discharge options for this patient that is difficult to place.*
>
> *Many attempts have failed to convey patient's poor prognosis of meaningful mental & physical recovery to family. They continue to be in denial. Can ethics get them to withdraw?*
>
> *We've tried chaplains, risk management, second opinions. The primary doctor thinks it is time to see if Ethics can help.*

The Ethics Expediter is expected to arrive on the scene as someone who can, will, and should "move things along" or, more often than not, move *people* along, as colleagues in various departments are concerned about length-of-stay, resource utilization, non-beneficial treatment, and so forth (Bramstedt & Schneider, 2005). When this expectation is manifest, typically the request for ethics consultation comes as a last resort, with a sense that since the usual institutional options and leverages have failed, there is something wrong with, *unethical* about, the situation and so now it is up to "Ethics" to break the logjam in the situation that has become untenable for the institution and unbearable for the clinicians or patient or family members at bedside. The ethics consultant as Expediter is thus taken to be skilled in ways that other members of the healthcare team or other forms of institutional mechanism are not in terms of getting things done, i.e., changing the course or direction of how clinical outcomes unfold.

A key issue and striking question that emerges from the idea of the Ethics Expediter, however, is whether, and why, values such as expediency and efficiency – and the implied cost savings—should be given priority in the context of ethics consultation and *for* the ethics consultant (Finder & Bartlett, 2017). That these values have always been prominent in the field of healthcare (Kisacky, 2017) does not necessitate that we, as a field and as practitioners, blindly embrace them. Though our individual models of and emphasis on *clinical* ethics consultation can respond expeditiously to requests, the process of ethics consultation takes time to explore values, concerns, goals, and available options—and sometimes both the process of

exploration and what is learned in the exploration is that more time is required, or that things are proceeding appropriately—even if not expeditiously (Rasmussen, 2006). To a degree, much of clinical ethics might consists of the following advice: "Don't just do something! Hurry up and stand there!"[2] Constructing a moral space (Walker, 1993) for clinicians, patients, and family members to explore the actual operative values present in a situation may, in practice, require resisting the prioritization of expediency, especially in the world of high-value healthcare where patient length of stay (for example) becomes a, if not *the*, primary marker of "value."

Ethics Healer / Ameliorator

> *Ethics consulted for physician distress and concerns about responsibility.*
>
> *Ethics consultation requested due to reports of team distress due to family disagreement with /protest against plan for discharge; asked for assistance in clarifying plan/discharge options.*
>
> *Disjointed treatment" with questions about management. Teams at odds with each other about Plan of Care. Can Ethics help clarify goals of care and surrogacy?*
>
> *Per Nurse, Psychiatry feels that getting ethics involved could be beneficial in supporting staff with this "difficult" patient.*
>
> *Ethics Consultation requested for staff support in light of challenging family member behavior.*

In these types of requests, ethics consultation is taken to be an institutional security blanket, of sorts: it soothes the sting of distress, navigates complexity, supports colleagues, makes it not so awful – whatever the "it" is, and however "awful" the "it" might be. Ethics consultation is thus expected to be comforting and to result in a kind of positive understanding of closure (Fiester, 2015). And this expectation is not unreasonable insofar as amelioration is assumed to be one of those foundational goods which undergird clinical ethics core competencies (ASBH, 1998, 2011).

Underneath this expectation, however, are two crucial assumptions. The first is that ethics consultation is *itself* therapeutic (Milliken et al., 2018; Schildmann et al., 2020). The second is that *the means* for being of help – clarification, facilitation, critical reflection—are, in the end, inherent goods, always to be valued and pursued (Friedrich, 2018). As with other presumptions held by various stakeholders in any ethics consultation situation, these two need to be probed and carefully considered (Bartlett et al., 2016; Zaner, 1994b).

We, like most in the field, would like to think our role is therapeutic. But if we take seriously the need for being responsible for the inquiry and reflection we pursue as ethics consultants, then we must also take seriously the possibility that our involvement and activities may make things worse, may further disrupt what might

[2] This was a favored phrase of Jan van Eys, MD, former chair of the Department of Pediatrics and founding chair of ethics at MD Anderson Cancer Center as well as former head of the Institute of Religion at the Texas Medical Center.

be an already tenuous balance, may raise issues and expose rifts or corruption within families or our own institution that, even if festering along, were in stasis before we started asking "What is going on?" (Finder & Bliton, 2011). Accordingly, we have to take seriously that in pursuing questions generated within any given circumstance in this "entrustable profession" (Kodish et al., 2013), even when the expectation is that our involvement will be a kind of *opening* which is hopefully helpful, in a given circumstance we might also be opening into the Abyss from which significant harm can ensue to individuals, to relationships, and to the circumstance at hand (Bliton, 2008).

Ethics Expert

> *Is a trach/PEG* [percutaneous gastric] *tube the ethical thing to do?*
>
> *Case Manager would like "a cool head and a fresh set of eyes" to look at this and offer recommendations with the ethical perspective.*
>
> *I'm also copying Dr. _____ in Clinical Ethics as well in case they would like to offer some expert commentary.*
>
> *We need a member of the Ethics team to participate to weigh in on the ethical aspects of her care.*

The idea of the Ethics Expert has been long debated in the field (Agich, 1990; Agich, 2005; Austin, 2017; Cholbi, 2007; Crigger, 1995; Moreno, 1991; Rasmussen, 2006; Scofield, 2018; Varelius, 2008; Watson & Guidry-Grimes, 2018; Yoder, 1998; Zoloth-Dorfman & Rubin, 1997),[3] and it is a complex and far from settled notion. On one end of the spectrum, in a vernacular, ground-level view, is the belief that ethics consultants, as "Ethicists," have by training and credentials definitive knowledge and information to apply or impart or pronounce on the "ethical issues" in question (Iltis & Rasmussen, 2016). On the other end, some expect the Ethics Expert to have the necessary playbook or checklist by which what to do may be calculated or derived (Dubler et al., 2009). In practice, requests for ethics consultation typically fall somewhere in the middle in which ethics consultants are seen as helpful because they help get a potentially *better* answer for some problem, crisis, or conflict than has been found up to that point in the clinical situation.

Accordingly, this idea of being the Ethics Expert may well be most seductive to our field in its efforts towards establishment and legitimacy, especially if what people mean by "Ethics Expert" is a person with experience and skill in investigating ethical and moral concerns; as Rasmussen clearly articulates and defends, there is "an expertise which not all possess but which is modest, helpful, and can be clearly articulated" (Rasmussen, 2011). But what people often mean is the "expert" who *knows ethics,* that is, knows what to do, or what "ought to be done," either because they know the right theories or have the right frameworks or checklists and so can pronounce *ex cathedra* about what is ethically justifiable or not. And when *that* is

[3] See also the entirety of volume 41, issue 4 of the *Journal of Medicine and Philosophy* (2016) which was devoted to this idea.

the expectation—and ethics consultants buy into and endorse that kind of expertise about the role—we are undercutting our own integrity (since even our best theories and clearest frameworks will not always tell us "what ought to be done" in a specific clinical circumstance). We thus risk throwing ourselves right back into our first three problematic expectations—of being Ethics Police or Ethics Equalizer or Ethics Superhero: because if we're the experts and we *know* that why wouldn't we know *who is being unethical* or why wouldn't we *know* when something is unfair and rain down appropriate judgment? Or if we are experts and *know* what needs to be done (or not), why can we not swoop in and fix whatever is wrong with the conversations, the medical plan, etc.? In claiming expertise in moral matters, we claim a particular kind of responsibility for those situations; "Ethics says so…" or "According to ethics…" thus starts to crop up in conversation and chart notes, while physician judgments and responsibility become less prominent. Deploying the political might of the Ethics Expert puts us at risk, in other words, of creating an environment in which, when push comes to shove, no one else *has to be* responsible because *we* are. And as a final problematic here, embedded within this expectation is that the ethics expert, however conceived, can and *will* get *the right* answer—an expectation no one, no matter who they are, can always meet in the dynamic world of clinical contexts.

"Nobody Expects the Spanish Inquisition"[4]

The above thumbnail sketches represent six different but common kinds of expectations we have frequently encountered within our work as ethics consultants. It has also been our experience that these expectations often are presumed or embedded in the discussions among those in the field of clinical ethics as displayed via the wide variation regarding the nature and goals of the actual practice of ethics consultation (Fox, 2016; Fox et al., 2021; Klugman, 2018). As a result, we believe there is little reason to doubt similar variation regarding the nature of and appropriate responses to such expectations within the field and by those currently engaging in clinical ethics practices (either as sole ethics consultants or members of ethics consultation teams or services).

In calling forth and being explicit about these expectations and some challenges embedded within them, we are not trying subtly – or not so subtly – to say that these expectations are or must be universally understood or that they are to be accepted as presented above; some expectations are, of course, context dependent and require their own particular response. Nor are we claiming that all expectations are per se problematic. Indeed, even with the six expectations we have outlined above it is possible to imagine specific contexts in which any one of them may touch upon significant ethical demands and dimensions confronting one or more individual in the given situation.

[4] ***Monty Python's Flying Circus***, Series 2 Episode 2, "The Spanish Inquisition," first broadcast 22 September 1970.

For instance, consider the expectation of an ethics consultant serving as the Ethics Police. While the typical understanding of "policing," which is bound up in the notion of the "Ethics Police," is that of "protecting" and "enforcing" (at least as we experienced it, as discussed above), policing entails more than these expectations; helping to resolve conflict or identifying problems or serving as a resource in times of crisis are also responsibilities identified with policing (ABA, 2020) and hence could, potentially, be what is expected when thinking of the ethics consultant as the Ethics Police. Accordingly, in the face of a physician who is ordering interventions against a patient's objections (see the first quote provided above in the summary overview of "Ethics Police"), calling for ethics consultation may be appropriate – not because the ethics consultant is expected to swoop in and "make things right" by "busting the physician" but because the ethics consultant may be able to think through the situation in ways that can lead to amelioration, including uncovering information not heretofore readily accessible that shifts the understanding about the apparent illegitimacy of the physician's actions or which solidifies that the physician is violating (for instance) Medical Staff rules. While either outcome may ensue, it is the skills the ethics consultant brings to the situation which is significant and hence what supports making the request for ethics consultation.[5]

Hence, again, we are not trying to argue against expectations per se nor are we simply trying to be contrarian, gleefully "scuttling the good in service to some unrealizable perfect,"[6] and neither are we discounting the goods that come from expectations in the sense of being accountable. Rather, our concern is to raise explicitly the idea that not all expectations about ethics consultation, whether held by ethics consultants or the patients, families, and healthcare providers with whom ethics consultants interact, are accurate or, more importantly, appropriate. Sometimes expectations are wildly unfounded; sometimes expectations are over-sized and overwhelming; sometimes they are politically manipulative; and sometimes they are ill-informed based on previous (and poor) experiences or previous (and poor) education. Sometimes they simply do not fit or apply to the circumstance at hand, and/or are inadequate or two-dimensional in the face of the clinical complexities from which most ethics consultations emerge. Most importantly, however, though mostly implicit and seldom made explicit, the six expectations we have named here include and contain important assumptions about the power, authority, responsibilities and roles of ethics consultants and ethics consultation which all who occupy and constitute the field of clinical ethics (and possibly Bioethics more generally) may be partially responsible for promoting (deliberately or not) as we have sought to establish ourselves as legitimate stakeholders and professionals in healthcare contexts. What is at stake is

[5] Similar imaginative variations may be done for any of the six kinds of expectations we have heretofore discussed whereby it may well be that within them are grains of legitimacy for requesting ethics consultation. We are thus not suggesting that the six expectations we have outlined are fully without merit (even if, in the ways they emerged in the requests we received, their problematic aspects were at the fore).

[6] This was a worry raised by Ellen Fox in her Plenary presentation, "Developing Standards for Clinical Ethics Consultation," delivered at the11th International Conference on Clinical Ethics Consultation in New York City on May 22, 2015.

whether those assumptions, and their associated expectations, are helpful, harmful, or some mix of both—and how.

For those expectations that are harmful or damaging because of the misunderstandings they create or perpetuate, the challenge is how to resist – especially when they seem to grant ethics consultants authority or power; even more so if such power or authority may not be warranted. And even when warranted, caution is advised; power and authority in general are not benign as they can make one complacent (at best) or even complicit (at worst) in a host of matters related to clinical ethics work[7]—and perhaps most important in the context of actually "doing" clinical ethics work, can work against the openness and understanding necessary for ethics consultants to engage with, and learn from, patients, families, and clinician colleagues about what values are operative in a given clinical situation (Bishop et al., 2010). Hence, ethics consultants encountering such expectations also encounter at least one *prima facie* need to resist—and hence the question of *how* to resist similarly necessarily arises.

Resistance is Fertile[8]

As a first step, we suggest that ongoing openness to resistance to these expectations seems to be in order. But by "resistance" we are not advocating anarchy in the field and in the clinic. Rather, we believe that resistance to the standard expectations is in order so as to create space for deliberate reflection on, discussion of, and education about our roles and responsibilities as clinical ethics consultants. In resisting typical expectations, in other words, we can be intentional and explicit to our colleagues—and to ourselves—about what it is that we actually *do* in our work and our orientation towards exploration and discovery of "what is going on?"—namely, asking questions, listening and talking, probing, venturing into the "behind the scenes" and into the undergrounds of clinical encounters, uncovering and discovering what is at stake and for whom and why (Zaner, 1996). Resistance, then, does not mean to dismiss, but to call into question, to explore and discover, and to be deliberate when fulfilling (or not) whatever appears to be expected.

It sounds remarkably, perhaps even ridiculously, basic. However, given that the every-day expectations that people carry with them and which inform their taken-for-granted understandings are part of the values and assumptions and commitments that shape and frame how a clinical ethics consultation unfolds, those expectations must be part of the clinical ethics consultant's purview and responsibility to explore, to account for, and respond to—sometimes explicitly as part of engagement in specific consultations (Finder & Bliton, 2011).

[7] This is a recurring point raised by Richard Zaner in the documentary film about his career: *The Life and Clinical Philosophy of Richard M. Zaner*. 2016. (Produced by SK Bartlett, VL Bartlett, MJ Bliton, SG Finder, available for free viewing at www.ohhe.org).

[8] To borrow from Banky's illustration, http://www.artofthestate.co.uk/Banksy/banksy-love-is-in-the-air.htm

In providing clinical ethics consultation on a day-to-day basis, we may not have to spell out and announce our resistance to the whole laundry list of potentially harmful expectations in every engagement, but we do need to be prepared to do so if these kinds of expectations emerge. And we must be able to manage proactively some of those expectations by articulating the responsibilities of and building expectations *around* the ethics consultant's actual activities (Chidwick et al., 2010)—especially activities of asking questions, of not always accepting the taken-for-granted, of engaging the clinical world critically, with the openness and uncertainty that comes from being not-like-the-others (Churchill, 1978; Schutz, 1964). Resistance is thus not an entrenched rebuff of expectations, but a deliberative embrace of the willingness to defy—not deify— expectations based on what actually is going on in the specific clinical encounter.

I Never Promised You a *Rose* Garden

In a world focused on quality metrics and efficiency and evidence-based *knowing* (Fins et al., 2016), and with explicit and implicit expectations, the ethics consultant is an odd kind of explorer (Bliton & Bartlett, 2018) who engages both the expected and the unexpected, the known and the unknown, the given and the uncertain—and does so in order to dig into what is presented, to see what comes up so as to respond responsively (and hence responsibly) to what we encounter (Bartlett, 2013; Finder & Bliton, 2001). This orientation, this commitment not merely to discover what is going on such that someone requests ethics consultation, but then to respond to that request in a manner that tracks whatever unfolds in order to identify, clarify, and give articulation to what is at stake for those individuals whose situation it is, then, should be held as at the core of any and all expectations associated with ethics consultation. And, reflexively, this entails the demand to address even the very expectations prompting, and possibly framing, the ethics consultation itself.

In the deep push to establish Bioethics in general, and clinical ethics consultation in particular, as an "entrustable profession," we hope to instill a moment of caution to clarify what the expectations of that trust might be and whether we—as individuals in particular contexts and as a field more broadly—see them as appropriate and achievable. This, as much as anything else, includes a challenge for each bioethicist, clinical ethics consultant, and those who engage in ethics consultation: of not getting caught by, and caught up in, the expectations of those with whom we engage—of not trying to deliver wished-for roses just because we've been digging in the dirt.

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