

# Narrative and Method in Ethics Consultation



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## Introduction

Method in ethics consultation has at least three distinguishable components: a canon, a discipline, and a history (Agich 2001). The term *canon* refers to the set of rules that guides the actions, cognitions, judgments, and perceptions involved in performing an ethics consultation. Because ethics consultation is a practice and not just a body of knowledge, the *rules* in ethics consultation are best thought of as the internal normative aspects of the actions that make up an ethics consultation. In a practice, the term *rule* has a special meaning. In a practice, rules are *enacted*. *Practice* is a technical term that was introduced into bioethics by Alasdair MacIntyre in his well-known book, *After Virtue*:

A practice may be identified as a set of considerations, manners, uses, observances, customs, standards, canons, maxims, principles, rules and offices specifying useful procedures or denoting obligations or duties which relate to human actions and utterances. It is ... an adverbial qualification of choices and performances, more or less complicated in which conduct is understood in terms of a procedure. Words such as punctually, considerately, civilly, scientifically, legally, candidly, judicially, poetically, morally, etc., do not specify performances; they postulate performances and specify *procedural conditions* to be taken into account when choosing and acting. (MacIntyre 1981: 55–6, emphasis added)

In the practice of doing ethics consultation, the rules are embedded in the practical actions and intentions of those performing ethics consultations. Some rules, of course, are articulated and even expressed formulaically. Slowther et al. report in a national study of clinical ethics services in the UK that

When asked about the use of decision-making frameworks, over half of the responders to this question (28/50, 56%) reported using the ‘four principles’ approach in the previous

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12 months. Other less commonly used frameworks were the Ethox approach (18/50, 36%), the Four Quadrant approach (5/50, 10%) and the Dilemma method (3/50, 6%). Some used more than one framework and 15/50 (30%) said that they did not use any. (Slowther et al. 2012: 212)

These findings, however, do not tell us how these frameworks function as rules that actually guide ethics consultants as they engage in the doing of doing ethics consultation. In fact, this finding only focuses on decision-making frameworks and gives no insight into the myriad of other rules embedded in what consultants actually engaged in as they perform ethics consultations. Nonetheless, this is a good example of the plethora of articulated rules for ethics consultation. Similarly, the rules and procedures in conflict resolution or arbitration approaches can be articulated, but they must be acquired and put into practice. That is why experience is essential for competent ethics consultation since rules can be enacted only through practice.

The term *discipline* of ethics consultation refers to the mastery, or at least possession, of the specific types of actions and intentions of ethics consultants which are guided by the rules that are embodied in the actions of competent ethics consultants. The discipline of ethics consultation importantly includes specific training/experience through which the consultant develops the requisite capacities for performing ethics consultation in a competent fashion. In this sense, ethics consultation as a discipline is constituted in practice and can be thought of as having a particular set of meanings that makes it a distinctive way of engaging in patient care. Although sharing family resemblances with other clinical consultations that occur in the course of patient care, ethics consultation has and is a unique discipline. Its purposes, actions, and range of outcomes are distinct and unique to ethics consultation as opposed to other clinical consultations.

The term *history* refers to the narrative of the actions, including the analyses, assessments, and communications undertaken in the course of the consultation; it also importantly includes reasoning about the practical issues and the steps toward resolving the ethical question or issues that arose. The various key actions, perceptions, and judgments of the consultant and others involved in the case are told or recorded. In the fullest sense, this would include any medical record notes made by the ethics consultant(s), the ethics consultation service case records of the case, and any personal narrative(s) of the case by the involved consultants. History, as an aspect of method, also includes the development of both the competence of individual ethics consultants or consultation services and the field as a whole (McCullough 2001). Any defensible history of ethics consultation should include the actual reasoning employed or reflection about not only the actions or processes followed by the consultants, but the values and norms which motivated the ethics consultant in undertaking the actions performed. Explanation of and the justification for the actions and recommendations of the ethics consultant may not always be communicated fully in the medical record notes, but should be at least documented in summary fashion within internal ethics consultation service records and

should be discussed in consultation case reviews. In this sense, the *history* of ethics consultation is not simply a set of narratives or stories about cases, but rather is, ideally, a set of critical reflections on both the actions and communications of ethics consultants in the course of doing the consultation and the decisions made or recommendations offered. The latter are often the primary focus of the discussion and review of ethics consultation reports or narratives clinical ethics cases, for example, in the course of ethics committee reviews as well as in the literature on clinical ethics cases. This focus on decision-making or recommendations, however, is unfortunate insofar as it tends to minimize the importance of the constituent actions and intentions that make up the process of doing clinical ethics consultations. The processes followed shape the case as it proceeds, and a good history captures this.

Critical reflection on the actions and communications involved in doing ethics consultation is essential not only in retrospective review of cases, but also in the process of actually performing an ethics consultation. I have argued that ethics consultation is best understood as a reflective practice and that the ethics consultant should be a reflective practitioner who is intentionally aware of and responsible for the actions and communications routinely undertaken in the course of an ethics consultation (Agich 2015; Schön 1983). These actions and communications include the phases of gathering information, assessment, interpretation, deciding which clinicians should be interviewed, when and how interviews and/or meetings should be conducted, as well as which individuals should be involved in the meetings. These actions, of course, are not undertaken in a linear fashion, but are adjusted to the particular circumstances of the case and are recursive, in the sense that they are often repeated. Thus, the phases of ethics consultation should not be conceived as a standardized or formal structure, but they are rather distinguishable aspects of what ethics consultants actually do in the course of their work. The ideal of ethics consultant as a reflective practitioner implies that competent ethics consultants will consciously and reflectively as well as responsibly engage in the component actions and engagements that compose an ethics consultation (Agich 2005: 14).

These points are not so much points in a *theory* of method in ethics consultation as a *description* of the key elements of what method *is* in the “doings” of ethics consultation. These points constitute a description of how ethics consultation is phenomenologically displayed if one makes a concerted effort to neutrally describe its essential features along a wide range of cases. As a doing, ethics consultation consists in actions and intentions that constitute a distinctive set of meanings in the clinical space of patient care (Agich 2005, 2009a). The meanings brought to patient care through the actions and communications of the ethics consultant shape to some extent the way that the case develops, though this can vary significantly depending on the actual circumstances of the case and the issues at hand. Hopefully, these meanings and interpretations as well as reflections are communicated in narratives about the case.

## Method as the Lens to View the Field of Clinical Ethics

How does this characterization of method in ethics consultation as a practice help us to understanding the field? First, the underlying concept of a practice requires us to focus on the actual “doings,” e.g., the actions, cognitions and perceptions of ethics consultants actually engaging in consultation. Second, viewing ethics consultation as a practice has the important implication that the question of method has to be regarded as a practical, and not a theoretical, matter. The rules involved in ethics consultation are first and foremost enacted and are phenomenologically manifested in and through the actions, cognitions, and perceptions of consultants. The rules are not and cannot be reduced to a formal code or set of guidelines or procedures that might be followed like a recipe. Instead, the rules, even when articulated linguistically, as they certainly must be for various legitimate purposes, are just abstractions from the lived experience of the practice and, importantly, they are dependent upon that practice for their ultimate meaning and justification. In this sense, statements about ethics consultation methodology, and theories of ethics consultation, are *secondary* to the actual practice itself.

Formal statements of rules of practice, of course, have a purpose. They permit individuals without directly relevant experience in doing the actual consultation to have meaningful discussions about it and they can have proactive effect in shaping the actual doings of ethics consultants. So, for example, understanding patient autonomy and patient rights, the right to information and to personal medical decision-making, provide a normative, conceptual framework for undertaking actions such as directly communicating with patients or their surrogates rather than relying upon the statements or reports of health professionals. But simply *knowing* or *understanding* the concepts of autonomy and medical decision-making does nothing to provide the communicative, interpretive, and decisional skills that are exercised by consultants actually engaged in ethics consultations as they go about respecting patient autonomy. These skills, the putting into action, as it were, of the ethical and legal concepts of patient rights are acquired and developed through the experience of actually performing ethics consultations – and not through knowledge as such. In other words, the knowledge of any doing or practice is properly and primarily expressed in the doings themselves, the actions that make up the practice. Like all practical activities, competence in ethics consultation is fundamentally acquired through experience, through learning and repetition, and not primarily through cognitive or intellectual learning. For novices in ethics consultation, the articulated rules or guidelines can help, but experienced ethics consultants, like experienced practitioners in any field, operate with rules in the background as it were. The rules come to be embodied and habituated in the actions of competent ethics consultants as they do in competent practitioners in any field.

In this sense, the rules of ethics consultation can be thought of as performative. In the philosophy of language, J. L. Austin introduced the concept of a *performative*

as a distinctive type of speech act (Austin 1962). The uttering of a performative is, or is part of, the doing of a certain kind of action, the performance of which is not just a “saying” or “describing” something, but essentially a doing (Austin 1962: 5). Whereas Austin was primarily concerned with speech acts as a mainly linguistic phenomenon, ethics consultation involves not just pronouncements as such might be articulated in a recommendation at the end of an ethics consultation, but in various other communications and actions. Since ethics consultation involves complex analysis, interpretation, communication, as well as reflection on the information associated with the clinical case, performative speech acts in Austin’s sense is only one component. Even with respect to speech acts alone, I tend to agree with Bach and Harnish (1979), who claimed that performatives are successful only if recipients infer the intention behind the literal meaning. So, when regarded solely as speech acts, performatives are acts of the social phenomenon and process of communication and involve the social construction of meaning. Even performative speech acts such as “I pronounce you man and wife” succeed not by conformity to convention as Austin seems to have it, but by the recognition by and acceptance by others of the intention of the person who does the communicating. The occasion of the marriage ceremony in which the pronouncement is articulated by a duly constituted official is itself a social construction with a frame of meanings. These meanings are enmeshed in these social frameworks. The success of performative speech acts as communication thus depends not only on an audience to identify the speaker’s intention and, in an important sense, to accept it, but also to understand and accept the background normative framework for the recommendations.

Despite the limitations mentioned, the linguistic concept of performative utterances is helpful to make an important point about ethics consultation, namely that as a practice ethics consultation essentially *is* nothing more than the various actions that constitute the meanings of the individuals involved in performing the ethics consultation. As ethics consultation services have become accepted in healthcare institutions, the consultations in many places take on a ceremonial aspect. In some, there is the ceremony of the family meeting or the healthcare team meeting in which crucial discussions occur and decisions are made. In other settings, ethics consultations are performed along the lines of clinical consultations by individual consultants or teams to function independently in the consultative capacity and independently make judgments about whether team meetings or family meetings are appropriate. In either approach, the meaningfulness of statements made in the course of ethics consultation are therefore fundamentally dependent upon the wider set of social meanings that provide a framework of acceptance of the particular doings of ethics consultants by patients, families, and health professionals (Agich 1995, 2000). This dependence can, however, become an uncritical habit or tradition that can function and be invoked unreflectively to justify recommendations or decisions. Such a routinization of actions—and justifications in ethics consultation—and their acceptance by the “audience” of patients/families and health professionals,

thus poses the danger that ethics consultation will itself become routine and occur without significant critical reflection. I will return to this point when I discuss the Zadeh Scenario in a moment.

To summarize, the question of method of ethics consultation is fundamentally tied to the complex construction or constitution of the social reality of ethics consultation in the clinical care of patients. Unlike performative utterances, which are mere speech acts, ethics consultation is much more complex in that it involves a performance that includes not just distinctive performative communications (as in the decision-making or the making of recommendations by ethics consultants, which are so often the focus of much discussion of clinical ethics cases) but also the constitution of meanings which comprises the interpretation and analysis of the clinical ethical circumstances of the case by the ethics consultant. The analysis and interpretation of actions and communications of those involved in the clinical care of the patient is thus a complex process that melds the meaning of ethical concepts, principles, and theories with the constructed and uncovered clinical and value meanings of the case.

## Method as a Lens to View Cases: The Zadeh Example

That said, how a case is understood and represented does disclose a great deal about the adequacy of the processes, namely the actions and communications, that make up an ethics consultation. Assessment and analysis of the way a case or clinical problem is presented is one foremost responsibility of ethics consultants and consultation services. Unless they fully accept this responsibility and act accordingly, their role will lack that structure and purpose that is central to the method of ethics consultation (Agich 2009b). The rules of the practice of ethics consultation are normatively framed in terms of helping to achieve an ethically justified outcome in a case. This is accomplished by providing advice on the ethical problems, confusions, conflicts, and questions that arise in the course of patient care. Defining what are the appropriate and defensible *ethical* concerns and distinguishing them from other concerns involved in patient care is rightly recognized as a central competence of ethics consultants (ASBH 2011: 12). Otherwise, consultants will function less as independent professionals and independent moral agents than as functionaries for others: health professionals or family members. If this happens, their role will shift from performing an *ethics* consultation to providing some other service such as emotional support. Providing emotional support, of course, is not unimportant in ethics consultation, but it is not the primary function of a competent ethics consultant. In ethics consultation, the primary function is to provide analysis and advice of the ethical and value concerns raised in the case. The primary focus should be the concerns relating directly to the ethically best course of care for the particular patient, but other important concerns such as supporting the family or health care

providers as they deal with the stresses involved in the case should be ancillary. In cases where the decision-making legitimately falls to surrogates, because the patient lacks decisional capacity which has been appropriately assessed, then providing emotional support for the surrogates becomes more important, but it is still secondary to addressing the ethical concerns and questions arising in the case.

How do these points on method help us to understand “The Zadeh Scenario”? Although I concur with the observations and criticisms so well-articulated by Frolic and Rubin (2018), Armstrong (2018), Tarzian (2018), Hynds (2018), and Rosell and Johnson (2018) that “The Zadeh Scenario” raises deep questions about the role, including the specific actions, of the consultants involved, as well as normative questions, I will not pursue them deeply. Suffice it to say that it is troubling that the narrative omits mention, much less critical discussion, of the patient’s wishes and values or reference to the ethical, legal, healthcare institutional policy, or professional guidelines which emphasize *patient* rights and should provide guidance about the responsibilities and limitations of the role of surrogates, family or otherwise. Also, no mention is made of the existence of an advance directive or discussions with the patient when she was functional about her preferences and values. Instead, the focus throughout is on decisions about specific medical interventions that are simply *presumed* to be within the legitimate and, indeed, the sole purview of the patient’s family rather than the patient herself or even, it seems at points, of the physicians. These omissions are troubling. Since the form of this narrative is not a formal ethics consultation report, it is hard to judge whether these concerns were ever addressed in the course of the actual consultation or were simply omitted from the narrative, so I will leave them aside. Pointing out these concerns, however, raises a question about the purpose and nature of “The Zadeh Scenario,” which affects how to approach it. Is it a narrative of an ethics consultation *as an ethics consultation* or rather a narrative of events and recollections about a long-running set of involvements with a particular set of family members, and health professional to a lesser extent, that occurred for a particular ethics consultant? There may be other alternatives, of course.

Given my focus on method, I will discuss some of the elements of the narrative that reveal the method used or as it is reported in the consultation, rather than dwell further on the more substantive matters. My focus is thus primarily on process aspects, such as communication among the consultants and the use of ethics consultation records, since these are the most prominent in the narrative. In the case of the narrator, Finder, we have his direct statements about some of his thoughts and actions, which we accept at face value, but in the case of his colleague, Steve Moore, we only have Finder’s report and no direct report by Moore of his actions and intentions. With these limitations in mind, we can nonetheless ask what methodological features stand out.

There are four that I will discuss: first, timely and direct communication among members of the ethics consultation service regarding on going cases, i.e., in this

case Drs. Moore and Finder, who are the only ones identified; second, written ethics consultation notes and records; third, the role projected by the ethics consultants through their actions and communications in the case; and fourth, the dynamic character of ethics consultations, which is most evident in complex and protracted consultations.

First, Finder's narrative provides a wonderful example of effective timely and direct communication among members of an ethics consultation service regarding on going cases. Although the consultation model demonstrated in this narrative is the individual consultant, effective and timely communication among members of ethics consultation teams or even committees in concurrent consultation is equally important. In this narrative, communication is reported to have occurred through the use of records of various sorts, including the electronic medical record and, presumably, of ethics consultation service records that it appears Finder reviewed at points and added to. The communication among the ethics consultants in this narrative is especially effective, because although Moore was directly involved over a long period of time, Finder was remarkably aware of many of the salient features of this involvement and details of the case. This included not only the content, but the tone and style of communications that Moore had with family members and other health professionals. Communication among ethics consultation service members is essential. Face-to-face oral communication and discussion about on-going cases is ideal, though not likely to occur regularly, such as in a team consultation settings in which members rotate. For this reason and because memory is not always reliable, as Finder noted at one point where he states that he wanted to write down his thoughts while they were fresh, good consultation service records are important. They can take many forms and a discussion of these forms is beyond the scope here.

However, consultation service records should include relevant factual data such as names and other identifying information of individuals involved, dates of service and a summary of the interactions with individuals, a summary of discussions, and impressions and interpretations that guide the consultant. Ideally, ethics consultation service records should include also some reflection on the normative guidelines relied upon and ethical analysis as it occurs in the case of the information encountered and the ethical justification or explanation of the actions, including recommendations made by the consultant. Such an ideal ethics consultation record would provide not only a summary set of statements of the encounters and actions that make up any ethics consultation, though each might be disconnected of course by the temporally discrete character of a case as it develops, but it should also include reflection on the individual instances of analytical, interpretive, reflective, and communicative actions that constitute the process of doing ethics consultation. Ethics consultation service records that primarily focus on recommendations made and the clinical circumstances or facts underlying those recommendations are, quite frankly, less useful and less likely to contribute to the development of a reflective practice, which I have argued should be the ideal for ethics consultation (Agich 2015).

Second, as already noted above, the narrative makes clear the importance of having and using written ethics consultations notes and records for ongoing ethics consultations. Such records are essential for quality improvement. They can provide a basis for peer review of the actual processes that make up complex ethics consultations and provide opportunities for reflections on how to improve existing practices. Having a record of the specific ways that individual ethics consultants attend to the questions or issues can point to differences in approach, which can be useful guides for ways to improve the overall practice of the consultation service. If the consultation service records only (or primarily) include documentation of case-related decisions, recommendations, or their explanations and justifications, it will be easier to miss those component actions that constitute and frame these outcomes. The importance of this point is easiest to see if one considers how one gains confidence and experience in any practical endeavor. Focusing on the outcome, the product produced, for example, by a craftsman cannot show the actual methods, the processes and procedures, and the underlying capacities and skills used to generate the result in question. To be able to effectively implement quality improvement in ethics consultation services' purposes, the review of cases must include critical discussion, reflection, and analysis of the processes and procedures undertaken by consultants as they do their work.

Third, the role that ethics consultants projects through their actions and communications is aptly illustrated in this narrative. Whether "The Zadeh Scenario" is an accurate or, rather, a full portrayal of the actions and communications we do not know, but taken at face value it is clear that several important normative ethical considerations are strikingly absent from this narrative. Instead, we have a picture of ethics consultants who seem to understand and so enact their primary role as that of providing "support," though it is never made clear how "support" is understood. What is provided is not just supportive listening to family members or emotional counseling, but making and reinforcing decisions about medical care that solidify the prerogatives of family members to make decisions. Since there is no discussion of patient wishes or of any deep exploration of patient values except as marginally provided by family members, the role that is projected in this narration is that of a sensitive communicator and counselor for family and, to some extent, health professionals, but not of individuals who are engaged in what might typically be called an *ethics* consultation. I say "to some extent," because the salient issue of moral distress of health professionals involved in this case over time is sidestepped in this narrative. This raises important issues about the usefulness of "The Zadeh Scenario" as a model for revealing how normative ethical considerations guide methodological choices made in doing ethics consultation, but, again, discussing that more fully is a concern beyond the scope of the present chapter.

Fourth, this narrative admirably demonstrates the dynamic character of ethics consultation. Not all ethics cases develop over long periods of time, but even within rather straightforward consultations there are episodes, such a receiving the request, validating or interpreting the issues or questions raised in the request, etc., that have

specific structures and within which various actions and intentions of the consultants are displayed. The purpose of good or comprehensive ethics consultation records, whatever their form, is that the processes followed by the consultants in the case as it develops over time are recorded and able to be analyzed. Since ethics consultants perform multiple kinds of actions, good records capture and express these actions and interpretations within the broad set of social interactions of multiple individuals involved in the case as they evolve over time. The dynamic character of ethics consultations is, of course, most evident in complex and protracted consultations that bring ethics consultants together with patients, family members, and health professionals over longer periods of time. But, even in straightforward ethics consultations involving, for example, providing a reminder or information about the applicability of a hospital policy to a case, the question or issue that is raised occurs at a particular time in the course of the care of a particular patient and the question or issue is raised by a particular individual involved in the case. Even in dealing with straightforward ethical questions or issues, ethics consultants thus step into and act as agents in patient care at particular point in the case's development. The point of entry, though not much discussed, can affect how the consultant functions and whether the consultant is able to function effectively as an *ethics* consultant.

## Conclusion

The dynamic character of clinical ethics cases is not surprising given the highly dynamic character of patient care, especially the care of patients who are seriously ill. This means that a substantial amount of information relevant to the ethical analysis of the case such as clinical data, no matter how seemingly straightforward, always have a timestamp and can expire quite quickly as circumstances change. Interpretations of data and clinical findings not only evolve over time, but are often diverse. Attending physicians, consultants, and other involved health professionals, not to mention multiple family members, can have different and even divergent understandings of the same "facts." This complicates the communicative process inordinately and can be one of the subtle points of divergence of opinion that is a source of conflict. Because ethics consultation typically occurs in the course of patient care in healthcare institutions which are also inherently complex, involving multiple healthcare professionals interacting over time and across shifts, ethical assessment must be recursive.

Moreover, good communication and reflection on that communication is a fundamental prerequisite for ethics consultants involved in a case. This means that as the patient's medical condition develops over time and as changes occur in healthcare personnel caring for patient and in the involvement of various members of the patient's family, the consultant must constantly reappraise and redefine the ethical

problems and challenges. In the latter case, the family of a patient present at the bedside may cycle through multiple individuals, which complicates communication and decision-making for all involved. This fluid character of patient care underscores the importance of critical reflection by ethics practitioners on an ethics consultation service in ongoing cases. When this reflection is weak or omitted, the involvement of the consultant loses focus on the primary ethical responsibilities associated with ethics consultation.

In this commentary, I have focused on the question of method in ethics consultation and outlined its salient features stressing the point throughout that ethics consultation should be a reflective practice. It is important to note that “The Zadeh Scenario” provides detailed description of the actions, communications, and reflections by Finder on his involvement in the case; it also includes statements about the actions and involvements of Moore. However, this narrative seriously omits critical reflection on normative aspects of the case or the purpose of the consultation as an ethics consultation. This appears to be at the bottom of what bothers each of the peer reviewers. Although “The Zadeh Scenario” does not provide a strong exemplar of critical reflection on ethics consultation, we cannot conclude that it did not occur. Its absence in the narrative, however, raises significant questions about the adequacy of this form of narrative as a narrative of *an ethics consultation* from which we can gain understanding and gain greater insight into how to improve our practices. That being said, the narrative does serve as a very useful occasion to reflect on the nature of method in ethics consultation.

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