Literature Review:
The Metaphysical Turn in Clinical Ethics Consulting

Reviewed by Julie D. Gunby, BSN, MSN, Ph.D.(c)

Malek, Janet. "The Appropriate Role of a Clinical Ethics Consultant's Religious Worldview in Consultative Work: Nearly None." *HEC Forum* 31, no. 2 (September 18, 2019): 91 – 102. https://doi.org/10.1007/s10730-018-9363-6.

For any person of faith who has ever wondered about the place of their religious commitments in the work of clinical ethics, Janet Malek has provided an answer —— nearly none. Although many of the earliest bioethicists were theologians, recent decades have shown a trend toward non-confessional ethics in the presentation topics of the American Society for Bioethics and Humanities (ASBH) and the articles routinely published in *HEC Forum, American Journal of Bioethics,* and *Bioethics*, but Malek is among the first to offer an explicit critique of "the role of a clinical ethics consultant (CEC)'s religious worldview in the context of clinical ethics consultation."

Malek argues that a CEC's personal beliefs should never influence the content of their ethical decisions nor how they frame an ethical recommendation. Instead, if the CEC's religious commitments are to play any role at all in their ethics consultations, they might on occasion, and with great caution, be used as a means of building rapport with a patient or family.

Malek's case studies clarify her meaning. If a patient asks a CEC what they personally would do when faced with a medically complicated pregnancy, a religious CEC cannot answer if that answer would reflect a view of abortion drawn from the CEC's religious tradition. If a terminally ill patient's family cites religious reasons for not implementing a do-not-resuscitate order, a religious CEC cannot use language from their shared tradition to reframe the discussion. Instead, the only time a CEC can draw on religion might be if, for instance, the CEC shares religious dietary practices with the patient and bringing up this point of similarity might help establish friendly relations for their decision-making.

The argument for seriously limiting the role of religion in clinical ethics proceeds as follows: 1) There is a bioethical consensus. 2) The bioethical consensus can be used without appeal to any tenets other than universally accepted, mid-level moral principles. 3) Appealing to principles, such as religious beliefs, that fall outside that consensus is bad, and it is bad for three reasons: a.) it imposes the CEC's views, contra patient autonomy;

b.) it yields inconsistent results, as opposed to a standardized consult; c.) it requires religious expertise outside the CEC's scope. Therefore, 4) CECs should use the bioethical consensus without appeal to religious principles except in very marginal, rapport-building ways.

For Malek, religious beliefs are "commitments and preferences" that "describe how the individual wants the world to be" and that might guide an individual's decision-making but "cannot be drawn on in conversations with others." This account of religion comes closer to describing a cross between Wittgensteinian private language and Freudian wish fulfillment than it does any standard account of orthodoxy or orthopraxy, and few religious practitioners are likely to recognize themselves in it. Nonetheless, many religious CECs who read Malek's article may find it hard to articulate what they find unsettling about her view.

Kornu, Kimbell. "Policing the Sublime: The Metaphysical Harms of Irreligious Clinical Ethics." ***Christian Bioethics: Non-Ecumenical Studies in Medical Morality,*** **Volume 28, Issue 2, (August 2022): 109 – 121. https://doi.org/10.1093/cb/cbac005.**

The physician and theologian Kimbell Kornu has recently criticized Malek's argument by taking her position at face value and exploring its theological and philosophical implications. Kornu asks what would happen if ASBH and the HEC-C certification commission adopted Malek's view and "prohibited CECs from drawing on their own religious worldviews in the work of clinical ethics consultation." Kornu coins a phrase to describe the potential danger — to implement such a position would cause "metaphysical harm" to clinical ethicists, to patients, and to clinical ethics consultation as an institution.

Understanding the phrase "metaphysical harm" requires understanding the notion of ontological violence, of which Kornu takes it to be a particular, concrete species. "Ontological violence" is a category that occurs in the work of Heidegger and Žižek, among other critical theorists, but to develop his account, Kornu turns to the work of theologian John Milbank, who lays out the history of the invention of the secular. On Milbank's reading of Nietzsche and the history of the modern West, Malek's proposal to require clinical ethicists to check their metaphysical commitments at the door may seem benign, but it is anything but. Any claim to normative secularity is an act of violence, asserting one metaphysics to supplant another — in this case, the nihilism of secularity forcibly replaces the theologically grounded ontology of peace.

Kornu's examples of metaphysical harm clarify his meaning. To insist on bracketing religious beliefs is to harm *the ethicist* by insisting they function as "a disengaged, buffered self," whereas with Malek's view, a CEC's job might be done just as well, if not better, by an artificial intelligence such as the prototype medical ethics advisor, MedEthEx. To deny validity to the transcendent metaphysical claims of a patient's religious beliefs is to harm *the patient* by silencing what may be their most important need as they face death and debility. To close off clinical ethics discourse from any metaphysical claims not grounded in secularism is to harm *the institution* by formalizing an obligation that sharply and dangerously curtails the limits of ethical discourse.

It is not always clear what mechanism of action causes metaphysical harms to occur, but the suggestion throughout is that any normative secularity that mistakenly believes it is devoid of metaphysical commitments smuggles in its commitments and foists them on others under the guise of neutrality. Given the magnitude of this harm, Kornu insists that an alternative constructive account of the role of religious belief in clinical ethics is necessary.

Brummett, Abram. "The Quasi-Religious Nature of Clinical Ethics Consultation." *HEC Forum* 32, no. 3 (January 3, 2020): 199 – 209. https://doi.org/10.1007/s10730-019-09393-5.

One of the most nuanced constructive proposals for the role of religious beliefs in clinical ethics consultation comes from secular bioethicist Abram Brummett, who argues against both Malek and the physician-ethicist Clint Parker. Like Kornu, Brummett thinks little good could come of implementing Malek's anti-religious injunction. But neither does Brummett want the bioethical community to consist of CECs who regularly invoke and disclose their deepest religious commitments as Parker recommends. As an alternative, Brummett proposes a metaphysically self-aware form of clinical ethics that he calls "quasi-religious" or a "moral-metaphysical proceduralism."

Brummett's most heated disagreement with Malek centers on her contention that it is possible to conduct bioethics without appeal to anything beyond purportedly "universally agreed upon" mid-level moral principles, and the most constructive elements of his proposal are modifications of her premises that there is a bioethical consensus and that there is a need to delimit the scope of metaphysical argumentation in clinical consultation.

When Malek argues that to cite a religious rationale imposes the CEC's views and contravenes the bioethical principle of patient autonomy, Brummett finds Malek's account of bioethics as thin as her definition of religion. Instead Brummett reminds us that clinical ethics consulting consists of more than fostering patient autonomy — there are guidance and intervention principles that dictate terms when patient preference must be overridden. Furthermore, there is no ethics apart from metaphysics. The central principle that allows ethicists to intervene in a plan of care is the harm principle, but even that archly clinical criterion includes tacit beliefs about what counts and doesn't count as a harm, and thus carries force in all those "aspects of human life deeply intertwined with religious belief, such as birth death, suffering, child-rearing, and human sexuality." The denial of metaphysical claims is itself a metaphysical claim, and Malek's argument falls prey to her own critique.

Debates within bioethics are often about the nature of bioethics itself, leading many who have engaged with Malek to reject her premise that there is a bioethical consensus. Brummett does not. However, he contends that the current consensus cannot function without formalized transparency as to what counts as consensus and without systematizing the process by which that consensus is achieved. Anything short of this risks the kind of metaphysical harms Kornu condemns.

Brummett also modifies Malek's claim that substantive religious discourse falls outside the scope of clinical ethics. Instead, he tells CECs who hold religious commitments at odds with the bioethical consensus, "Disagree but obey, and know where to make your case." That is, Brummett highlights the need for a distinction between the clinic and the academy in terms of metaphysical discourse. Just as athletes must follow the rules of the game on the court, they can also petition the sport's governing body for changes if the current guidelines seem unfit. The insight here is that proceduralism is important for standardization, but unreflective proceduralism goes awry and requires the protective effect of metaphysical reflection.

SYNTHESIS

In any argument about the role of religious beliefs in clinical ethics, it is important to recognize that religious commitments are being "bracketed," not erased. In fact, it is precisely the nature of religious and metaphysical commitments to govern when such bracketing is permissible. Recognizing the perdurance of metaphysical commitments suggests the need for a conversation about conscientious objection not just in clinical medicine, but in clinical ethics consultation as well.

By focusing on the role of religious commitments in "secular" clinical spaces, the argument suggests that no such complications would arise "in an environment where a specific religious perspective shapes institutional policies and the commitments of individual providers." Nonetheless, religious commitments are rarely uniform within traditions, and it is possible, for instance, for Catholic CECs to have moral qualms about the content of the *Ethical and Religious Directives (ERDs)*. Brummett's "disagree but obey" solution suggests a potential framework for this in-house moral quandary as well, reminding religious CECs of their obligation both to practice in accordance with existing moral directives and to work conscientiously to influence the underlying theological discourse.

In a time of increasingly polarized debate, it is all the more important that ethicists identify the root causes of our disagreement. All three articles point to the profound significance of the metaphysical turn in clinical ethics. If religious clinical ethicists feel a tacit marginalization in professional bioethics, and if they find themselves self-policing their beliefs in their clinical work, Malek's forthrightness enables an open debate about whether and to what extent that circumscription should be the case. The fact that Kornu, a theologian in the radical orthodoxy tradition, and Brummett, a professed atheist, argue to the same conclusion suggests that the turn to metaphysics offers promising ground where thoughtful clinical ethicists can engage with the issues of greatest importance. ✣

JULIE D. GUNBY, BSN, MSN, PH.D.(c)
Ph.D. Student, Theology and Health Care Ethics
Saint Louis University Albert Gnaegi Center for Health Care Ethics
Paul Ramsey Fellow and John Wesley Fellow at Saint Louis University
St. Louis
julie.gunby@slu.edu