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Introduction

Denise M. Dudzinski and Paul J. Ford

The first edition of *Complex Ethics Consultations: Cases that Haunt Us* in 2008 did not anticipate that "cases that haunt us" would become part of the bioethics lexicon. Variations of this phrase have become regular themes in papers, panels, and conversations. The phrase acknowledges the complex, unpredictable, and uncontrollable circumstances typically encountered in ethics consultation. It also engages the affective, moral, and professional complexities and doubts ethics consultants' experience. Now, when we talk about a *haunting case*, it invites a confessional style of reflection marked by candor and humility. The speaker places trust in the listener, asking for grace, forgiveness, compassion, and assistance. Witnessing each other's achievements as well as missteps has helped our practice mature, fostering a kind of guild where new consultants take solace in the fact that respected senior ethics consultants also experienced loss, grief, and bewilderment. The cases in the first edition remain relevant and remain unchanged for those purposes. We added a new chapter in each section. New authors reflect on what has been learned since publication of the first edition. The concluding chapter has also been substantially revised.

Many things have changed in 15 years. The *Core Competencies in Healthcare Ethics Consultation* were updated, with yet another revision in the works. Ethics consultants can now become certified in healthcare ethics consultation (signified by the Healthcare Ethics Consultant-Certified [HEC-C] credential). Bioethicists played pivotal roles during the COVID-19 pandemic, influencing policy and practice at national, state, and regional levels. Staff moral distress captures more of our time and attention. Our practices have changed for the better, as clinical ethicists examine the privileges they previously neglected to acknowledge and challenge. New authors in this edition look back on the 2008 cases with attention to inclusivity and equity, providing important framing and context. It is astounding that so many of the cases in the 2008 volume are still familiar in contemporary practice.

We invited seven respected colleagues to read and reflect on one section of the book, providing new insights about how ethics consultation has evolved over 15 years. Each section includes four original cases and a new chapter with further reflection. Each new author was asked to answer four questions: (1) What are the most powerful lessons that remain relevant in today's practice of ethics consultation? (2) How might the consultations be carried out differently today? (3) How would you appraise the presence or absence of equity, diversity, and inclusion in case discussions and reflect on their impact on the quality of the ethical analysis and reflections and (4) In the future, how should ethics consultation better address affective components of clinical ethics practice? These authors help us critically differentiate practices to be commended from those we can set aside in favor of greater incisiveness, compassion, and inclusion, welcoming the voices of historically marginalized patients, families, and ethicists.

Lucia D. Wocial, PhD, RN, FAAN, HEC-C reviews the cases in Part I, “Starting at the Beginning: Prenatal and Neonatal Issues.” Wocial implores clinicians and ethics consultants to “take a deep breath and pause,” resisting the pressure to make rapid decisions in the midst of value uncertainty. All ethics consultants have felt this pressure, and we often need to take a few deep breaths ourselves before encouraging the team and family to do the same. Wocial highlights the importance of helping the team convey the care and concern they have for parents struggling with end-of-life decision-making for neonates, “When parents feel that the team cares *about* their baby and *for* them as parents, trust is fostered.”

Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM reviews the cases in Part II, “The Most Vulnerable of Us: Pediatrics.” Reflecting on both the practices of the treating teams and ethics consultants, she highlights the need to trust the family and to “uplift the child’s voice sooner,” especially when children have experience with the treatments in question, as Susie did in “Susie’s Voice.” Sederstrom points out that we continue to miss opportunities to truly understand the patient’s and family’s values. She reminds us of the perils of failing to do so. She also describes the vital role empathy plays in antiracism and reducing bias in patient care. True empathy replaces defensiveness with curiosity, humility, kindness, and gentleness.

Maya Scott, MSW, LICSW reviews Part III, “Diversity of Desires and Limits of Liberty: Psychiatric and Psychological Issues.” Regarding Chapter 9, “Helping Staff Help a ‘Hateful’ Patient: The Case of TJ,” she highlights the harm of ascribing the dread and apprehension we feel to the patient with monikers like the “hateful patient.” Bias and unjustified assumptions can infuse our unfiltered and uninformed perception of patients, masking our own racism, ableism, classism, etc. Scott writes that in reviewing the chapters in this section, “[she] grappled with experiences of human suffering, the powerlessness we feel when we are unable to help, our own shame-based reactions to some of the anger that we feel when we are pushed to our limits, the cumulative impact of the trauma that frontline and consulting teams absorb, and the overreaches of power.”

Crystal Brown, MD, MA considers Part IV, “Withholding Therapy with a Twist.” End-of-life decision making has been and is likely to continue to be a frequent subject of ethics consults. In the years since publication of the first edition, ethics consultants have come to work side by side with palliative care professionals. Brown encourages such collaboration as she emphasizes the necessity of skilled communication to navigate end-of-life decisions and elicit patient, family, and clinician values. Brown highlights the value of feminist ethics in attending to lived experiences while also revealing and expanding the loci of power.

Mahwish U. Ahmad, MD, MPH, HEC-C reviews Part V, “The Unspeakable/Unassailable: Religious and Cultural Beliefs.” She echoes the advice of many authors, advocating empathy and “taking the time to listen without judgment as the gateway to addressing cultural value conflicts, creating trust between the patient and the hospital team/ethicist.” Ahmad writes that she empathizes with Bena, a pregnant, unmarried adolescent who asks her doctor to withhold information about her pregnancy from the women accompanying her in order to evade the risk of ostracism from her community. Listening without judgment may be one of the best ways to respectfully interact with people from cultures with which we are less familiar. Clinicians’ concerns about truth-telling are balanced against Bena’s needs and values, even when counterintuitive from the perspective of clinicians who are unfamiliar with her culture. Ahmad also reflects on the changing transplant landscape over the past 15 years, where the appeal of *narrative* gains force through social media. Social media means unrelated donors are more easily enlisted.

Kaarkuzhali B. Krishnamurthy, MD, MBE reflects on the cases in Part VI, "Human Guinea Pigs and Miracles: Clinical Innovations and Unorthodox Treatment." Krishnamurthy notes the importance of conflicts of interest when considering whether to abide by a request for amputation from a patient with complex regional pain syndrome, even when no one recommends surgery. She asks ethics consultants to be more explicit when examining conflicts of interest, such as instances when surgeons factor in potential litigation when deciding whether to proceed with surgery. Today, we also see more patients and families favoring herbal remedies, and Krishnamurthy highlights the unfavorable terms used by healthcare providers for the surrogates in such circumstances: difficult, abrasive, bully. She reminds us of the ethics consultant's role in dispensing with such terms and seeking to understand the beneficence motivating the surrogate's request.

Ruchika Mishra, PhD reviews Part VII, "The Big Picture: Organizational Issues." The organizational structure of a hospital impacts bedside decision making, and Mishra notes that working in teams tends to reduce organizational missteps and encourage an inclusive culture. "[M]any health care organizations across the country are focused on creating a culture of speaking up to reduce opportunities for errors and ensure pathways to quickly identify and rectify issues." The thoughtful incorporation of bedside realities in hospital policy can provide an additional support structure for staff. Proactive policy development can give staff practical strategies to fairly address complex patient care issues. Persistent bed and staff shortages post pandemic give Chapter 28, "Who's That Sleeping in My Bed?" more contemporary import, as complex discharges arise more frequently in ethics consultations. Looking to the future, Mishra writes, "There has been a steady forward movement in terms of identifying and addressing potential ethical problems before they take root; actively soliciting diverse perspectives; supporting a team approach; improving transparency; and extending available educational opportunities."

We are grateful to these seven authors for helping us view the 2008 cases in the changing light that time and enlightenment bring. They have given us the gift of insight and wisdom by encouraging readers to embrace change, even when it comes with some trepidation. They also help us discern when we should stand true, as we did 15 years ago, despite contemporary pressures toward expediency.

The identities and clinical and/or social details of patients and colleagues have been changed to protect their privacy while preserving the narrative. We extend our deep gratitude to the patients, clinicians, families, authors, and colleagues. Their sensitivity to ethical issues and commitment to the well-being of everyone in their care have made all the difference.

Introduction to the First Edition

Live and Learn: Courage, Honesty, and Vulnerability

Paul J. Ford and Denise M. Dudzinski

Introductory Comments

The cases in this volume exemplify a rich cross-section of consultation experiences from which we can learn. The authors tell stories and share personal responses connected to deeply affective clinical ethics cases in which they consulted. None of these authors has selected an easy case. Ambiguity, second-guessing, and regret permeate their stories and reflections. They show great courage in laying bare such things as potential missteps, institutional impotence, and interpersonal struggles. Through their openness, we have amassed a rare collection of stories from which to learn about real-life challenges encountered by clinical ethics consultants in the incredibly complex world of contemporary health care.

Although overarching themes emerge in this volume, these cases should be read with an open mind since these themes may not be those stereotypically found in bioethics textbooks. Our cases identify challenges including uncertainty about decision-making capacity, limiting treatment requests, and obligations of health- care providers to protect patients. The cases go beyond just tragedy. They touch on uncertainty, lack of power, and unclear professional boundaries that blend to create a mix of end-of-life, quality-of-life, organizational, and societal concerns. Naturally, the end-of-life cases represent a significant portion of this volume given the high stakes. In these end-of-life cases the endorsement of withdrawal of therapy comes alternately from families and healthcare providers. As we see from experience, the role played in a case, whether patient, family member, physician, nurse, or ethicist, does not always predict the source of a therapy-withdrawal request. Clinical ethicists neither uniformly support withdrawal of therapy nor always agree with the physician's opinion. We have purposely included cases that go beyond this stereotype since troubling cases occur in outpatient practice, institutional policy discussions, quality-of-life interventions, and when considering clinical innovations. The cases in this volume cover a broad range encountered in a variety of healthcare settings. In the final chapter of this book we provide guidance as to how these cases may be used in education. Below we provide general thoughts, discussions of cases, and review of selected themes to provide a richer context for reflecting on the cases.

Specters, Traces, and Gegret

Clinical ethics consultants inevitably engage in cases that haunt them long after a formal involvement ends. As with patients, families, and care providers, ethics consultants remain moral agents with culpability for their interactions and recommendations. When consulting, ethics consultants necessarily weave themselves into the story of the case. In doing so, they influence the path of these stories, and they themselves are altered

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by those encounters. Standard ways of writing ethics cases focus on particular ethical issues rather than the role of, and affective impact on, the ethics consultant. Case analyses must blend substantive ethical issues with personal challenges consultants experience to get the full effect of the complexity of clinical ethics consultation. At times no good solution to a dilemma exists, organizational or legal constraints seem insurmountable, and/or the consultant is unable to bring about a result. Although ethical dilemmas should be discussed for the sake of the dilemmas themselves, sharing the affective nature of complex situations plays an important role in a consultant's professional development. By acting with integrity ethics consultants recognize their shortcomings and improve practices. Having the courage to write about these cases helps others in the field recognize the personal and professional risks of ethics consultation. Sharing haunting cases may improve the practice of clinical ethics consultation by addressing the character and professional development of consultants. Sharing these stories with clinicians and patients improves understanding of good processes needed in our current healthcare settings.

Clinical ethics consultation can be haunting for several reasons. First, there is the challenge of ethical issues themselves, which can be stressful when helping others negotiate a resolution. These elements create tense environments in which the stakes can be high. Second, a clinical ethics consultant's judgment as to when and how to intervene in a particular case influences the processes within clinical care. The involvement is not always beneficial and may occasionally cause harm. Third, consultants experience moral distress and uncertainty similar to the distress and uncertainty experienced by those being helped. Fourth, consultants often feel powerless to facilitate positive change when tragedy and suffering are pervasive or organizational constraints seem intractable. Finally, once consultation commences, our values become part of the complex dynamics, either incorporated constructively or stumbled over on the road to clarity. These elements blend to create consultation experiences that long influence and affect us.

Clinical ethics consultants influence cases, if in no other way than by bringing greater understanding of individual and professional values, thereby fostering decision making. While they may encourage others to courageously express and negotiate values, consultants also risk harming others and being harmed themselves (Bliton & Finder, 2002, 233–58; Zaner, 1996, 255–77). To do consultation well, consultants need to empathize with other participants to fully appreciate the circumstances. This empathy is balanced by careful reasoning and reflection in order to influence a case to the best ends possible. To be effective, consultants invest themselves in the devastating circumstances of others and attempt to assuage suffering by facilitating critical reflection. Emotions and facts are important to the dynamics of ethics consultation. The balance of the cognitive and the emotional often manifests itself in the terms "subjective" and "objective." This is seen in a number of cases in the text, such as those contributed by Swota and by Woodrum and McCormick. Losing some "objectivity" is not necessarily negative. The subjective will not necessarily mislead the consultant if it is balanced by clear articulation and understanding of the reasons and context of the case. Consultants can positively influence circumstances by integrating experiential and analytic elements.

Hauntings must not paralyze consultants, as might be a natural response to being emotionally overwhelmed. To communicate effectively often requires recognizing the ambiguity, sorrow, uncertainty, and lack of closure inherent in many consultations. For instance, Macauley and Orr articulate a warning against being “driven to incapacitating doubt” that is echoed through numerous cases (Macauley & Orr, p. 18). Paradoxically, being haunted can also foster further professional growth and reflection that prompts increased activity. To whatever degree these special cases influence our activities by means of paralysis, growth, or anxiety, it is clear that they contain significant affective components. They influence consultants beyond their professional activities. Grief and sadness borne of tragic and frustrating cases may linger when returning to families and social circles. Given the small community of bioethicists in any given geographic area, isolation may preclude confidential debriefing, thereby confounding attempts to process these emotions. Sharing, reading, and discussing cases may decrease the sense of isolation and demonstrate that consultants are not, in fact, alone in coping with the emotional “baggage” of their work. We hope this book will provide support and facilitate open discussion.

Sections, Divisions, and Organization

The cases in each section are grouped by theme for certain educational purposes. However, given the depth of challenges in each case, many cases have multiple themes so that alternative ways of organizing are just as plausible. With that in mind, in the final chapter we suggest several ways to reorganize and outline teaching, discussion, and professional growth uses. Below we provide an overview of each book section.

The first section, *Starting at the beginning: prenatal and neonatal issues*, focuses on prenatal and neonatal issues. The four cases could be interpreted as pairs of cases addressing similar problems. Robert Macauley and Robert Orr’s discussion of an end-of-life decision in the neonatal intensive care unit contrasts with David Woodrum and Thomas McCormick’s case. Macauley and Orr discuss withdrawal of therapy on a neonate that seemed to have been accelerated over a weekend. The process of deciding is quick and did not give many on the primary team or other family members knowledge of the imminent event. Of particular note in this case is the commitment to quality improvement premised on the existence of discernible ethics consultative errors or less effective ways of doing consultation. However, the critique is tempered by the understanding that any retrospective analysis of a particular situation relies on reports rather than direct experience. The quality of ethics consultation should not be based on a bad medical outcome or on information not reasonably available at the time of the consultation. Ethics consultation is imprecise and is undertaken in the face of uncertainty. Retrospec- tive review and criticism should be based on the information and opportunities reasonably available during the moment of decision making.

In a neonatal case where withdrawal of aggressive therapy is recommended by the medical team, Woodrum and McCormick reflect on how long the case drags out. The team anguishes while watching the baby suffer and the recommendation for withdrawal is not accepted. How should law and ethics interface in solving cases? The authors propose a legal resolution to protect the baby from undue suffering. However, in the end they believe appealing to the law may be a futile endeavor. This case provides a nice counterpoint to the first case, in which the process of deciding went very quickly.

The second two cases in this section relate to perinatal issues. Richard Zaner describes parents faced with a complicated pregnancy for which there is a great deal of prognostic uncertainty. The 22-week fetus might have spina bifida, suggested by ultrasound and alpha-feto protein tests. In speaking with the patient, Zaner discovers a subtle source of distress. The patient is astounded that such a profound decision must be made quickly, before the age of viability and without adequate clinical information. Zaner attempts to help the parents make critical treatment decisions in the midst of excruciating medical and moral uncertainty. Zaner reflects on the familiar haunting of moral decision making when the possibility for a devastating "mistake" is immense and the patient's vulnerability is great.

Mark Bliton reflects on the decision of a woman to undergo innovative maternal–fetal surgery to repair a neural-tube defect. Similar to Zaner, this story centers on a pregnant woman faced with an intractably difficult decision laden with uncertainty. In conversation with the patient, Bliton attempts to be sensitive to a suffering woman facing potentially tragic outcomes while also encouraging exploration of hidden ambiguities and value questions that she may be avoiding. Bliton's uncomfortable conversations before and after the fetal intervention prompt him to reassess consultation processes and his own values. In many ways, the uncomfortable conversations described by Bliton and Zaner challenge our underlying value assumptions. These hauntings, bred of uncertainty and lack of information, strike at the very foundation of clinical ethics consultation.

In the second section, *The most vulnerable of us: pediatrics*, cases divide evenly between inpatient and outpatient concerns. Douglas Diekema and Jeffrey Spike highlight the way cases unfold differently when physicians believe it to be premature to withdraw life-sustaining therapy and when they believe withdrawal has been delayed too long. These cases also reflect the dual roles that consultants play, with Diekema being a physician who treated the patient but subsequently acts as an ethics consultant and Spike being a nonphysician who is unexpectedly thrust into a communication role he believes should be undertaken by a physician. In Diekema's case, he treats a young girl in the emergency room who is then admitted to the intensive-care unit. His subsequent ethics consultation is further textured by the resonance he feels with the family's religious tradition. He discusses the relevance of his relationship as provider and of his sympathy and understanding of the family's religious perspective toward his ethics recommendations.

Spike describes an ethics consult called by providers who believe life-sustaining therapy should be withdrawn. The baby has sustained severe traumatic neurological damage for which the mother is criminally charged. Spike reflects on how he, as the consultant, is forced to balance a number of competing visceral reactions to an incarcerated mother who comes to her baby's bedside in chains. Is the mother who allegedly hurt the baby entitled to see her? What role should the consultant play when the physician leaves the "family" meeting to the ethics consultant? In both Spike and Diekema's cases, the consultant resists being persuaded by simple consensus but is sympathetic to the clinicians' commitment to protect a vulnerable child.

Two narratives describe complex pediatric cases where patient care occurs outside a hospital setting. Rosa Lynn Pinkus, Stella Smetanka, and Nathan Kottkamp describe a child who refuses additional chemotherapy after her cancer returns. A complex dynamic emerges among the physicians, family, lawyers at a university law clinic, and the clinical ethicist. They explore the role of the ethics consultant as a mediator, patient advocate, or consultant. Most strikingly they highlight a broken therapeutic trust and a young girl trapped by the conflict. The patient and her family select an option offered by the physicians not to undergo another round of chemotherapy. Only after they choose this option are they informed that the physician never considered it a genuine option. The family experiences this as a "bait and switch," having been told they had a choice while the medical team was only really willing to allow one of the options. Providers may believe they are adhering to standards of "informed consent" by including options they do not recommend or are unwilling to provide. Although undertaken with good intentions, this can be devastating to the therapeutic relationship.

In Micah Hester's account, the patient has a chronic need for a ventilator and is unable to participate in the decision-making process. The issues center on children who rely on medical technology in both inpatient and outpatient settings. The physicians advocate for "comfort care only" while the parents strongly prefer that the child be cared for at home and continue with intensive medical support. Hester reflects on the lack of definition of his role and regrets that he did not meet directly with the parents. Hester discusses the difficult interface between inpatient and outpatient medical care.

In the third section, *Diversity of desires and limits of liberty: psychiatric/ psychological issues*, cases center on patients with psychiatric issues or mental status alterations and highlight that patients and professionals may have radically different notions of "beneficial" treatment goals. In the chapter by Joy Skeel and Kristi Williams, the patient continually makes self-destructive choices that alienate him from his care providers. During episodes of multiple readmissions, the patient has been labeled as "hateful." The consultant finds herself mediating between the individual medical services such as medicine, psychiatry, and nursing. Further, she attempts to mediate between the health-care providers and the patient. The case raises questions about the ethics consultant's power to help and perhaps prompts regret that a more effective approach might have been missed.

Barbara Daly and Cynthia Griggins describe a patient who espouses mutually exclusive desires and goals. He has quadriplegia and does not want to be turned for decubitus wound care but also does not want to die from the sepsis that recurs because of poor wound care. In the end, the authors recommend a "Ulysses contract," which overrides the patient's decision to decline dressing changes when wound care is initiated but provides the patient with the power to dictate the timing of the care. Weekly they negotiate this agreement with the patient at which time he can decline the contract and transition to comfort care only. The authors underscore the power imbalances for disabled patients who are profoundly dependent on medical staff and who also lack family or other advocates. In reflecting on the role of the consultant, the authors ponder whether they should be negotiators or advocates. They also recognize that unlike the nurs- ing staff, they do not have to experience the patient's protests when the contract is being enforced. They are insulated from the anguish of implementing their recommendations.

Paul Ford describes a patient with limited and sporadic cognitive function whose designated decision makers are at odds with the medical team. There is disagreement as to what would be best for the patient and what would be acceptable medical practice. The clotting off of a dialysis catheter sparks a futility discussion. Ford feels trapped in an institutional process designed to protect the disparate interests of patients, physicians, and the institution, but the process is neither expedient nor smooth in reaching a satisfactory conclusion in this case. The case questions the reactive nature of consultation and the need to occasionally deviate from policies that exact a heavy cost to all parties.

Debra Craig and Gerald Winslow describe a woman refusing to eat, which the family accepts after a while. Craig and Winslow use this case to explore the complexities of being a physician ethics consultant and to reflect on alternative approaches to consultation. The patient is discharged in the care of the husband and receives hospice nursing even though a terminal diagnosis was never found. The retrospective review of the case by the ethics committee provides a reminder of the importance of quality improvement. This reflection on peer review resonates with the earlier discussion by Macauley and Orr.

The fourth section, *Withholding therapy with a twist*, addresses the traditional question of withdrawing life-sustaining therapy; except these cases all have unusual or unexpected features. Ellen Bernal begins the section attentive to process and role. Reflecting on an experience from early in her career, she describes a woman in a Catholic hospital who consistently requests discontinuation of therapy. However, both her physician and her husband will not allow her wishes to be fulfilled. She relies on secondhand and thirdhand reports about patient wishes while the patient continues to be awake and communicating. She looks to the attending physician for “permission” to be involved. Like Ford, she reflects on the constraints of following institutional processes too rigidly. Finally, she emotionally describes the level of responsibility a clinical ethicist should assume for patient outcomes and the potential cost to interprofessional relationships. Expectations of responsibility are generated by both the ethics consultant as well as those who request the consultation. A failure of those expectations can exact a significant personal and interpersonal cost. Bernal frankly articulates how, given her current experience, she would have handled the case differently.

Joseph DeMarco and Paul Ford describe a case where a family requests withdrawal relatively soon after surgery. DeMarco provides the perspective of an academic bioethicist in his initial introduction to the world of bedside clinical ethics consultation. He observes the surgeon’s mild resistance to ethics involvement, stemming from the surgeon’s belief that he knows how his patient’s care will proceed. The surgeon’s stance changes dramatically by the end of the case, when he looks to the consultants for resolution, or absolution, after conceding that withdrawal of therapy could be enacted. It may have been the consultants’ lack of verbal support for the surgeon during the family meeting that led him to agree to withdraw therapy. A consultant’s aptly chosen silences in a family meeting can sometimes have as much effect as speaking volumes.

George Agich warns against blindly trusting reports about the medical facts of a case and advises consultants to avoid being used as a perfunctory ethical validation for a preconceived course of action. He discusses ventilator withdrawal with a patient and suspects the patient needs further clinical clarification of treatment options. The patient confuses the burdens of a tracheostomy in general with those she experiences because of the size of the tube. Agich demonstrates his listening acumen, which is informed by his philosophical training and his long experience as a clinical ethicist. He was able to discern essential gaps in communication. He demonstrates challenges commonly faced by nonclinician ethics consultants, such as acquiring basic knowledge of clinical facts and being familiar with the clinical context. Agich acknowledges but disputes the common perception that clinical ethicists support a “culture of death” by favoring withdrawal.

In Stuart Finder’s case, he wonders why a broken jaw precipitates withdrawal of life-sustaining treatment. After exploring various perspectives, the rationale becomes clear. However, a weekend call from an administrator prompts him to second-guess whether further follow-up should have been undertaken before “signing off” on the case. Finder raises questions of how far cases should be pursued and when the consultation is closed. It can be tempting to judge a case to be complete when plans of care resonate with the consultant's personal values. In the end, the question of the influence and responsibility of the ethics consultant's actions must be recognized.

The sixth section, *The unspeakable/unassailable: religious and cultural beliefs*, addresses cases that involve cultural and religious influences on belief systems. Donald Brunnquell begins this section with a striking case of an adolescent with an ectopic pregnancy. He raises questions about confidentiality, coercion, and honesty in exploring how to respond to a young girl who could become a cultural outcast if her tight-knit community discovers her sexual activity. Is threatening the girl with police involvement if she neglects medical follow-up justified if her mother is not going to be told? Should the ethicist condone lying to the mother? Balancing the social values with the physical well-being of an adolescent becomes difficult in a cross-cultural setting. The consultant's limited access to cultural information interjects significant uncertainty.

Tarris Rosell explores living unrelated kidney donation. Religion factors into the donor's motivation to put herself at risk for a fellow member of the congregation with whom she is not well acquainted. In transplantation, ethics consultants are often asked to explore motivation, reasons, and potential coercion. Rosell explores the challenges arising from the donor's being "directed by God" to donate, the lack of an emotional connection with the recipient, and the potential for secondary gain. He also reflects on the appropriateness of recommending counseling and the apparent disregard for the consultant's recommendations. As other authors in this volume have noted, consultants must be cognizant of the burden imposed when counseling is recommended or mandated by the ethics consultant.

Physician-ethicist Kathryn Weise helps to resolve a conflict by developing and arranging an alternative-care plan while acting as an ethics consultant. She arranges for a hospice to accept a patient on a ventilator with an agreement that the ventilator will be withdrawn soon after arrival. This appears to respect a variety of the participant's desires and values. Not only does she reflect on the family's Islamic beliefs concerning medical care but also on the appropriateness of the bioethicist in coordinating discharge and being responsible for creative care solutions. Regarding the twist at the end of the case, she wonders whether she ignored her training and obligations as a physician while assuming the role of an ethicist. Perhaps by insisting on explicit consideration of stressful ethical and treatment issues, she contributed to the tangible harm that the patient's mother experiences.

Kathrin Ohnsorge and Paul Ford describe a patient who relies on a direct communication from God to make his healthcare decisions. They analyze both the hermeneutics of the case as well as the degree to which the consultant's use of religious language can be deceptive and manipulative. Finding a balance between a consultant's knowing about religious traditions, calling on those who are expert in spiritual matters, and leaving spiritual discussions to others can be very challenging. Consultants should strive for transparency, avoid manipulation of patients, and exemplify respect for patient beliefs. Also, the authors consider the possibility that a student-teacher dynamic could have influenced the consultation. Just as in medicine, we should not minimize or dismiss that trainer-trainee relationships may potentially confound the consultation.

The sixth section, *Human guinea pigs and miracles: clinical innovation/ unorthodox treatment*, involves variations in clinical practice that raise difficult issues. Denise