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The practice of balancing in clinical ethics case consultation

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Abstract

Models for clinical ethics case consultation often make reference to 'balancing' or 'weighing' moral considerations, without further detail. In this paper, we investigate balancing in clinical ethics case consultation. We suggest that, while clinical ethics services cannot resolve ongoing deep philosophical debates about the nature of ethical reasoning, clinical ethicists can and should be more systematic and transparent when balancing considerations in case consultations. We conceptualise balancing on a spectrum from intuitive to deliberative, and argue that good balancing in case consultation involves *articulating reasons* for giving something more or less weight. We develop a framework of four practical strategies for better balancing in clinical ethics case consultation: intuitions as a launchpad, drilling down, pairwise comparison and group deliberation.

Keywords

Cryobanking of sperm, ova and embryos, ethicists and ethics committees

Introduction

Over the last 30 years, clinical ethics services and literature about clinical ethics have burgeoned. Over this same period, various approaches to generating recommendations in the specific context of clinical ethics have been published, including the four boxes method,[1] moral case deliberation,[2] and the Zurich model of paediatric ethical decision-making.[3]

These models for deliberation about clinical ethics, and other models like them, often make passing references to the metaphor of 'balancing' or 'weighing' moral considerations. For instance, the Zurich model recommends that consensus about an appropriate course of action ought to be achieved, in part, by attempting to '[b]alance [the] benefit and burden of each option' (Streuli et al.,[3] p.630). A similar recommendation is made by advocates of moral case deliberation, when they describe a method for dealing with clinical ethical dilemmas that advises healthcare professionals to '[d]iscuss possible group consensus or decision ("weigh" values & norms)' (Molewijk et al.,[2] p.124). Similarly, in their most recent statement of the four boxes method, Jonsen et al.[1] have suggested that 'a resolution can be reached and formed into a recommendation' through the '"weighing" and "balancing" of moral considerations' (pp.4–5). Sokol[4] has highlighted that there is a lack of detail about how balancing could best be incorporated into the four boxes method. We suggest that this problem extends further, to the practice of balancing in clinical ethics case consultations more generally. Despite the integral role that balancing or weighing moral considerations plays in clinical ethical decision-making (as these authors suggest), none of these models are supported by a meaningful account of what this entails.

In this paper, we investigate the practice of balancing in the context of clinical ethics case consultation. We do not aim to standardise an approach to balancing or to put forward an algorithm for balancing incommensurable ethical considerations. Such standardising is, in our view, neither achievable nor desirable given the varied ways in which clinical ethics case consultation is conducted around the globe. Rather, we are

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interested in the very practical question: how can clinical ethicists – whatever their context – balance better?

We begin by reflecting on cases concerning paediatric fertility preservation from our own clinical ethics experience, in which balancing was a crucial but opaque step in our process. We suggest that, while clinical ethics services cannot resolve ongoing deep philosophical debates about the nature of ethical reasoning, clinical ethicists can and should be more systematic and transparent when balancing considerations in case consultations. We conceptualise balancing in terms of a spectrum from intuitive to deliberative, and argue that clinical ethicists should work to make their balancing as deliberative as possible when consulting on cases. To assist with this process, we put forward four strategies to promote articulation of reasons when balancing in clinical ethics case consultation.

Balancing as a crucial but opaque step in clinical ethics consultation: Two cases

In our experience, the notion of balancing is often invoked and used in clinical ethics case consultations. This aligns with the very limited empirical literature investigating how clinical ethicists and committees reason.[5] In this paper, we will draw on a series of clinical ethics case consultations about procedures aimed at fertility preservation for young children with cancer, in which the concept of balancing was central to our reasoning.[6] For the purpose of further investigating balancing as a process and a concept, we outline two illustrative cases below. These cases are amalgams, drawing on our experience of many clinical ethics consultations on fertility preservation. (For ease of expression, throughout the paper we will discuss these children as if they are individuals.)

Case 1 – Ellie

> Ellie is a three year old girl diagnosed with brain cancer. She is about to start treatment that gives her a 80% chance of survival into adulthood, but carries a high risk of significantly compromising her future fertility. Her parents are aware of the possibility of a surgical procedure aimed at fertility preservation and are considering this for Ellie. They understand that the procedure is unproven. Ellie has not had any previous gonadotoxic treatment so the chance of retrieving healthy ovarian tissue is high, but the process for ultimately achieving a live birth remains experimental. The surgical procedure is quite simple and low risk, but requires a general anaesthetic. It could be done at the same time as she is having a general anaesthetic for a procedure that is part of her cancer treatment, so the fertility procedure would not delay or compromise the cancer treatment.

In our setting, the clinical ethics team meets with the treating team for a collaborative discussion about the case.[7] In Ellie's case, we essentially articulated and compared the perceived benefits and burdens of the procedure specifically for her. The main benefit was an increase in Ellie's chance of becoming a genetic parent in future, with a degree of increase that is impossible to quantify as yet (since there are no data on which to perform a statistical calculation). The risks and burdens included discomfort during recovery, risk to the function of the ovary from which the tissue is taken, and potential infection at the surgical site. Risks of the general anaesthetic and psychological burdens from the experience of going to theatre were reduced by having the tissue taken at the same time as a procedure under general anaesthetic that would be done anyway as part of Ellie's cancer treatment. The additional risk of a somewhat longer anaesthetic is quantifiably very low, and there is no additional psychological burden, as there is only one trip to theatre. The group's reasoning used the notion of balancing, and our recommendation was framed in this way, using the phrase 'on balance'. The burdens and risks seemed low, particularly in the context of the burdens of her cancer treatment overall. The benefits too were perceived to be quite low, particularly given the dependence on future scientific advances to develop a reliable pathway to genetic parenthood using prepubertal tissue. But the view of the group was that the benefits were sufficient to justify the burdens and risks, making offering the procedure ethically justifiable. Our conclusion was that, *on balance*, offering the procedure was ethically justifiable.

Case 2 – Aiaysha

> Aiaysha is a six year old girl with a rare form of lung cancer. She had chemotherapy two years ago, which shrank the tumour, but it has started to grow again, and a more intensive chemotherapy regimen is now needed. The first dose was given last week. Because of the previous chemotherapy, some damage may already have been done to Aiaysha's ovaries. Aiaysha also has another medical condition (not life-threatening) which makes her more prone to bleeding than other children. Aiaysha is quite anxious in hospital, and finds the process of having surgery quite frightening, though the hospital staff have managed her anxiety well for previous procedures. Aiaysha's parents are interested in her having a fertility procedure, despite understanding that it is far from

guaranteed to work, but only if her doctors think it is a good idea.

In this case, the group's ethical reasoning again proceeded as a process of balancing, but the recommendation was different. The balance of benefits and burdens was seen as different to Ellie's case. The potential for Aiaysha to achieve genetic parenthood in the future is less than for Ellie, because her ovarian tissue may already have been damaged. In addition, the burdens to Aiaysha are greater. First, she would have to have an extra surgical procedure, which is not necessary for her cancer treatment, and hence she is exposed to all the risks and burdens of a surgery that is entirely avoidable. Second, the bleeding issue puts her at a somewhat increased risk of complications after surgery, which would not be life-threatening, but could make healing slower and more uncomfortable. Third, simply having any surgery is a psychological burden to Aiaysha. Overall, in comparison to Ellie, the risks and burdens to Aiaysha are increased (but still not high in absolute terms) and the potential for benefit is decreased (though not to zero). The group judged that, on balance, the burdens outweighed the benefits for Aiaysha, and the recommendation was against offering the procedure.

These two cases show how balancing plays a crucial role in generating recommendations in clinical ethics case consultations. The ethical question in both Ellie's case and Aiaysha's case is the same: is it ethically justifiable to offer the fertility preservation procedure to a prepubertal child given the limited evidence for efficacy? It was the balancing process that resulted in different recommendations in these two cases. Without some balancing process, it is difficult to see how a recommendation could be made in these cases.

In these cases, balancing was about comparing benefits and burdens. In other cases, different moral considerations might also be important in the balance, for example parental authority. In our view, balancing need not always be exclusively focused on benefits and burdens, but in many cases in our experience in paediatrics, this type of benefit versus burden balancing is the focus of case deliberation.

Reflecting on our practice in these types of cases, questions arose for us. In each case, the step in reasoning where we went from discussing the benefits and burdens to the final recommendation is unspecified. How exactly did we go from the set of benefits and burdens to the view that offering the procedure was justified? How were we actually comparing them? What justified our view of the final balance? How could we articulate this justification? That final step of comparing the benefits and burdens seemed an intuitive judgement, shared by the group involved in the consultations and emerging through the course of the discussion, but opaque in some significant way.

Distinguishing intuitive and deliberative balancing

Within the philosophical literature, balancing has been discussed and debated. This broader debate is about how we should reason in bioethics given potentially conflicting principles (or norms or values), rather than in the specific practical context of conducting clinical ethics case consultations.

Most philosophers writing about balancing (whether they are criticizing or defending the practice) agree that there are at least two distinct forms of balancing.[8–10] The first is 'intuitive balancing', which is described by DeMarco and Ford[8] as follows: 'In *intuitive balancing*, reasons are not offered to support the decision that one value is of greater importance than another involved in a particular conflict' (p.491). This is the type of balancing we described in relation to the fertility preservation cases; the justification for the balance is not explicitly articulated, leaving this sense of an opaque step in reasoning. It is worth noting that intuition is a contentious and ambiguous concept amongst philosophers; there is not a consensus view about the nature of intuitions, their justification or role as evidence.[11] We use intuition in the non-deliberative, purely evaluative sense – the 'gut feeling' conception.

The other form of balancing is labelled 'deliberative' or 'justified' in the philosophical literature. This type of balancing requires that reasons justifying the judgement are provided. DeMarco and Ford[8] call this method 'deliberative balancing' and Richardson[10] uses the label 'justified balancing'. DeMarco and Ford[8] suggest that '*Deliberative balancing* provides reasons for believing that one value has greater importance than another' (p.491) while Richardson[10] writes that acts of justified balancing 'are based on underlying reason' (p.298).[12] From these two definitions it should be clear that the slight difference in terminology does not suggest a different target concept; for simplicity's sake, we will use the label 'deliberative balancing' going forward.

In this literature, intuitive and deliberative balancing are conceptualised as a dichotomy. We propose, however, that intuitive and deliberative balancing should be conceptualised not as two qualitatively distinct subtypes of the process of balancing, but rather as the two ends of a spectrum. A particular instance of balancing may fall somewhere on the spectrum between completely intuitive (with no stated reasoning) and fully deliberative (with specific and comprehensive reasoning stated).

We propose that balancing well in clinical ethics case consultation means balancing as deliberatively as possible. As clinical ethicists, we should work to move any balancing as far along the spectrum towards the deliberative end as we can (Figure 1). In a case consultation, once the morally relevant considerations have been defined, we need to articulate reasons in support of the balance tipping in favour of one course of action over another, rather than going straight from a list of considerations to an 'overall' recommendation.

This is because the outcome of a clinical ethics case consultation is a plan for action, and so our balancing should not be opaque to those involved in the case. Clinical ethicists and committees are essentially asking health professionals to implement the results of their ethical analysis. They are also implicitly asking patients and their families to accept the recommended approach to care. Thus, transparency is crucial. In the philosophical literature, Richardson[10] has argued that acts of intuitive balancing necessarily fail the 'requirement of publicity' because 'there is no actual quantitative dimension backing them up and [because they fail] to encourage the public articulation of the actual, qualitative bases of such judgments' (p.297). This requirement of publicity is particularly relevant in the context of clinical ethics case consultations. As clinical ethicists, we want our analysis to be understandable and open to questioning by those parties affected by our recommendations. Purely intuitive balancing leaves little room for any form of fine-grained engagement with a recommendation made by the ethicist or clinical ethics committee. Similarly, intuitive balancing within a consultation could be seen as limiting the scope and depth of the analysis during the case discussion itself. It is better for both the clinical ethicist or committee and all stakeholders if the processing of balancing is as well-articulated as possible.

Strategies for good balancing in clinical ethics case consultation

In this section, we offer a framework of four strategies to assist clinical ethicists and committees to make their balancing as deliberative as possible (Figure 2). The interrelated strategies are intuitions as a launchpad, drilling down, pairwise comparison and group deliberation. As a framework, these strategies aim to help ethicists and committees move our thinking in clinical ethics case consultations from this form: 'Moral consideration A is important' to this form: 'Moral consideration A is more important than moral consideration B because Reason/s X (Y, Z)'.

We are not putting forward these strategies as a sequence of necessary steps, but rather as some broad approaches to assist clinical ethicists and committees to operationalise a commitment to more deliberative balancing.

1. *Intuitions as a launchpad*

Of course, many moral considerations are not commensurable.[10,13] Ellie's and Aiaysha's cases clearly demonstrate this. Comparing, for example, the risks associated with a general anaesthetic with an unquantified increase in chances of genetic parenthood in future is far from straightforward. There is no common unit by which these two considerations can be measured. They seem to be qualitatively different considerations that cannot be placed on the one scale in a way that is fully explicable and defensible. However, we suggest that such considerations can be, and often are, compared intuitively in case consultations. Many people, in our experience of such fertility preservation cases, have the intuition that an increase in chances of genetic parenthood is more important than the risks associated with a general anaesthetic in this context. Generating intuitions about how moral considerations balance can be a useful starting point for more deliberative balancing. Such intuitions can function as a launchpad for closer analysis by identifying points of disagreement.

For example, members of a clinical ethics committee could approach an incommensurable comparison in the following way. Let us imagine that the committee is considering three moral considerations in a fertility preservation case: an unquantified increase in chance of genetic parenthood, the risks associated with a general anaesthetic and the child's preference not to have the procedure. These are incommensurable considerations; however, each member of the committee could be invited to try to compare them by giving each consideration a score out of 10. How important is the general anaesthetic, on a scale of 1–10? How important is the increased chance of fertility, on a scale of 1–10? Of course, no such objective scale exists, but intuitive judgements can be made as a starting point. Comparing intuitive judgements within the group identifies key points of disagreement that require further discussion and analysis. For example, all members of the group may rate the increased chance of fertility over the risk of the general anaesthetic. Yet, when comparing increased chance of fertility with the child's hesitation, there may be some members who see the increased chance as more important and some members who see the child's hesitation as more important. If this situation arises, then it is clear that substantial further discussion of the second pair of considerations is required. These gut feeling balances can be used as a starting point for comparing incommensurable

considerations, particularly for identifying which of these require further discussion and detailed analysis by the group.

2. *Drilling down*

Articulating reasons in support of the balance tipping in favour of one course of action over another requires drilling down into the nature of the concepts and values being used in the discussion. It also requires detailed thinking and evidence-gathering about the factual questions relevant to the case.

Drilling down involves understanding the nature of the relevant concepts and their meanings. Unpacking the concept of fertility is important in Ellie's case. What is valuable about fertility? Is it the genetic connection to one's children? Or is the activity of parenting the key value? What are the alternative pathways to realising these values? How do these values link to other broader values like autonomy or an open future?

Alongside discussion of concepts and values, drilling down also involves finding answers to empirical questions. Particularly in relation to the benefits and harms being considered, information about probability, magnitude and reversibility will be crucial. Empirical questions may overlap with the values discussion, for example what is the evidence that cancer survivors value genetic parenthood? Ultimately, a process of drilling down – interrogating concepts, values and empirical information – is necessary to articulating reasons.

Drilling down is likely to reveal significant points of disagreement amongst members of the clinical ethics team, clinicians, patients and families. This will be particularly true of drilling down that analyses the nature of concepts and values relevant to the case. Given the differences amongst people's deeply held moral commitments and the diversity of views about the good life and human flourishing, this strategy will reveal rather than necessarily resolve some of the competing understandings of concepts important to the case. Drilling down is likely to be complex and potentially difficult, but valuable in articulating reasons.

3. *Pairwise comparison*

We should aim to articulate reasons for weighting one consideration more heavily *than another*. Balancing is always comparative. It is not just about a consideration's weighting, but ultimately about whether some considerations *outweigh* others. So pairwise comparison can assist in our process of articulating reasons. We are aiming to be able to say that one specific consideration is more important than another specific consideration for a particular reason or reasons.

To clarify how this process of pairwise comparisons might unfold, let us look back at the case of Ellie. The fertility preservation procedure offers two potential benefits to Ellie: (1) an increase in her chance of becoming a genetic parent in future, which is difficult to quantify and (2) the knowledge that caregivers tried to keep the option of genetic parenthood open to her. When considering the risks and burdens that the fertility preservation procedure posed, there are four relevant considerations: (a) the risk of an unintended negative impact on her future gonadal function, (b) risks associated with longer time under general anaesthetic, (c) risks associated with fertility preservation surgery – chance of infection, etc. and (d) minor discomfort during recovery.

Given this list of potential benefits and burdens, there are eight possible comparisons that could be made (e.g. 1 versus A, 1 versus B… 2 versus A, 2 versus B…) Pairwise comparison is most straightforward when the two considerations being compared are clearly commensurable. For instance, when looking at Ellie's case it is apparent that both 'an increase in her chance of becoming a genetic parent in future' (Benefit 1) and 'the risk of an unintended negative impact on her future gonadal function' (Burden A) were morally significant only because they could affect Ellie's chance of future genetic parenthood. We can weigh these two considerations against each other directly, by determining if the surgery is expected to increase or decrease her chance of fertility overall when both considerations are taken into account.

After such straightforward comparisons take place, we could then move on to determining if the predicted increase in Ellie's chance of genetic parenthood outweighed each of the other burdens. Does this potential benefit outweigh the minimal risks associated with general anaesthetic (Burden B), the other surgical risks (Burden C) and any minor postoperative discomfort Ellie would feel (Burden D)? Does the predicted increase in Ellie's chance of genetic parenthood outweigh each of these considerations individually? If so, does it outweigh all of them in combination? We could continue the process of pairwise comparison by weighing the benefits associated with Ellie having knowledge that her caregivers tried to keep the option of genetic parenthood open to her (Benefit 2) with each of the potential burdens.

This process of pairwise comparison brings into focus the relative importance afforded to all of the relevant considerations. In particular, it would allow us to clarify that the primary positive value at stake here was the predicted increase in Ellie's chance of genetic parenthood. Consequently, any judgements that were made about this case (or other similar cases) would be highly sensitive to the ever-evolving empirical

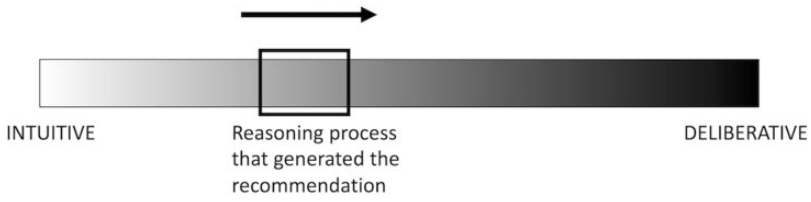

Figure 1. A spectrum from intuitive to deliberative balancing.

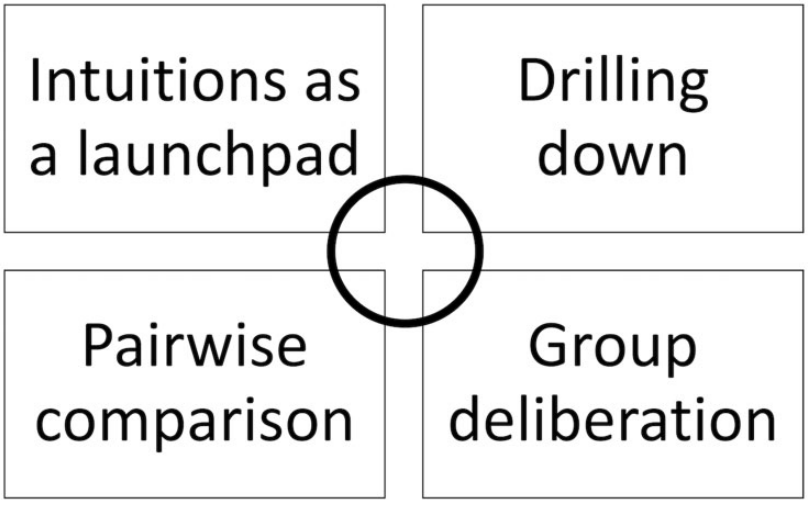

Figure 2. A framework of strategies for good balancing in clinical ethics case consultation.

evidence about the effectiveness of prepubertal fertility preservation procedures.

The strategy of pairwise comparison offers a means of clarifying precisely how the ethicist or committee's overall judgement is being motivated. Through pairwise comparison, a more detailed account of the constituent parts of their headline judgement becomes available for scrutiny.

4. *Group deliberation*

The strategies can be used by individual clinical ethicists or by groups deliberating in settings where a team model is in place for case consultations. However, in our view, a group approach to clinical ethics case deliberation is, in itself, a strategy that facilitates balancing that is more deliberative. Discussing a case as a multidisciplinary group brings diverse perspectives to the analysis. This diversity forces us to articulate reasons for our views and helps us to see our own biases. In working towards generating a recommendation as a group, there is an inbuilt invitation to reflexivity. Reflexivity is a concept from qualitative research, in which the researcher reflects on the way in which his or her own position and experience influences the conduct and findings of the research.[14,15] The encouragement to reflexivity is built into group deliberation, as individuals encounter conflicting views, probing questions and new perspectives. This process facilitates better balancing by pushing individuals to articulate reasons in order to support their views in a context where they are respectfully challenged.

Conclusion

Clinical ethicists sometimes speak of balancing as if it is a fairly straightforward, systematic and consistent part of our reasoning. But, as Veatch[16] has written in the broader context, '[i]t can be argued that a balancing theory is nothing more than an elaborate rationale for letting preconceived prejudices rise to the surface' (p.209). We need to be more attentive and methodical in articulating reasons in our balancing in clinical ethics case consultations. Otherwise, there is a danger that when clinical ethicists 'balance', we are simply presenting our gut feelings using more neutral and authoritative language.

The four strategies that we have presented aim to assist clinical ethicists and committees to make their balancing as deliberative as possible. Better balancing

can be further supported by documentation formats that prompt, for example, pairwise comparison and recording of reasons. *Recording* reasoning is crucial to the ultimate goal of achieving greater transparency. Excellent balancing within the room discussing the case does not achieve this goal unless the reasoning is also accessible to stakeholders through documentation. There is a potential chain of positive influence here: a documentation format that prompts good balancing, influences the reasoning process positively, which is then recorded for potential scrutiny by stakeholders.

Overall however, the framework we have presented does not eliminate the risk that balancing becomes a post hoc justification of an initial intuition or gut feeling. Only an awareness of this risk, combined with a genuine willingness to revise one's view, can protect against this problem. The process of articulating reasons implicitly implies that new information or insights would require a revisiting and potential revision of the recommendation. Ultimately, good balancing relies on all of us being open to changing our minds.

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