

Default Positions in Clinical Ethics

Parker Crutchfield, PhD is Associate Professor in the Department of Medical Ethics, Humanities, and Law at Western Michigan University Homer Stryker M.D. School of Medicine in Kalamazoo, Michigan.

Tyler S. Gibb, JD, PhD, is Co-chair of and Associate Professor in the Department of Medical Ethics, Humanities, and Law at Western Michigan University Homer Stryker M.D. School of Medicine in Kalamazoo, Michigan.

Michael J. Redinger, MD, MA is Co-chair of and Associate Professor in the Department of Medical Ethics, Humanities, and Law and Associate Professor in the Department of Psychiatry at Western Michigan University Homer Stryker M.D. School of Medicine in Kalamazoo, Michigan.

ABSTRACT: Default positions, predetermined starting points that aide in complex decision-making, are common in clinical medicine. In this paper, we identify and critically examine common default positions in clinical ethics practice. Whether default positions *ought* to be held is an important normative question, but here we are primarily interested in the descriptive, rather than normative, properties of default positions. We argue that default positions in clinical ethics function to protect and promote important values in medicine—respect for persons, utility, and justice. Further, default positions in clinical ethics may also guard against harm. Where default positions exist, there are epistemic burdens to overturn them. The person wishing to reject the default position, rather than the person endorsing it, bears this burden. The person who bears the burden of meeting the epistemic requirements must provide evidence proportional to the degree of harm the default position protects against. Default positions that protect against significant harm impose significant epistemic requirements to overturn. This asymmetry not only makes medical decision-making more economical, but it also serves to promote and protect certain values. The identification and analysis of common and recognizable default positions can help to identify other default positions and the

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

conditions under which their associated epistemic requirements are met. The paper concludes with considerations of potential problems with the use of default positions in clinical ethics.

Keywords: Decision-making; evidence; default position; harm; evidence; epistemic burdens

1. Introduction

When clinicians make recommendations about the treatment of patients, they may often rely on default positions. Default positions are similarly common in clinical ethics consultation. One goal of this paper is to substantiate this claim. For example, a default position is that patients in a healthcare setting enjoy a presumption of capacity sufficient to direct their own treatment. This default position, like all others, is not sacrosanct and may be overcome with appropriate evidence, as we explore below. Default positions, as used in this paper, are distinct from heuristics or ‘rules of thumb’ in two important ways. First, default positions are understood here to be generally accepted by a group of people (i.e., practicing clinical ethicists) rather than being idiosyncratic to a single clinician. Second, default positions are not short-cuts to meaningful ethical inquiry, but are starting points. Default positions in clinical ethics, or any other default positions, may lack robust justification, such as that offered through *a priori* reasoning, empirical evidence, or moral reasoning. This is not to say that there are no reasons for the positions, just that it is neither necessary that the position arises from reasons nor that if it does, those reasons suffice to justify holding the position. But whether one *ought* to hold default positions is distinct from whether one *does* hold default positions. We are primarily interested here in the descriptive, rather than normative, properties of default positions in clinical ethics consultation praxis. In clinical ethics default positions are common, perhaps because they serve some important functions. (Hart and Halpern 2014) They tend to promote efficiency and economy in medical decision-making. They conserve effort and resources. Default positions may provide a gatekeeping function such that if a particular decision passes the default

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

condition, it may move more effortlessly to a next step in the decision-making process. Indeed, a prominent view of cognition holds that the mind works this way too: no cognitive resources are expended when incoming stimuli conform to the mind's default expectation of what is likely. (Hohwy 2013; Clark 2013)

The utility of defaults is not limited to increasing economy and efficiency. They also help to promote or protect specific values recognized by the group adopting the default positions. This is true of other defaults in other settings, as well. A ground fault circuit interrupter (GFCI) electrical outlet defaults to being on, unless it is forced to bear too great of an electrical load, in which case it switches off. The GFCI outlet, as compared to other electrical outlets, better protects against damage—it promotes safety. Defaults in clinical ethics have similar protective functions (though the analogy does not extend so far so as to imply that default positions in clinical ethics are connected to electrical currents). These defaults represent the promotion and protection of moral values. There may be legitimate disagreement about whether a default position in fact promotes or protects a particular value or whether the default position ought to be other than it is. But this disagreement focuses merely on the contents of the default (e.g., disagreement about whether advance directives help to secure patient preferences) and has no bearing on the simple fact that default positions in clinical ethics exist (e.g., that advance directives should be pervasive) and that these default positions represent the promotion or protection of values.

Default positions are functionally important in clinical ethics because where there is a default position there is an asymmetric burden of justification relative to that position. If the default position is the proposition that p , the person endorsing that proposition bears no burden of justification in adopting it. Rather, the person rejecting that p bears the burden of justification in rejection of the proposition that p . Where the burden of justification rests and when it may flip, like a GFCI outlet, have significant practical and clinical implications. Who shoulders the burden of justification may determine whether a patient's sternum gets crushed in the course of administering CPR or whether a patient dies because a potential organ donor never opted in to donation. What the switch is set to and the burdens required to flip it may be matters of life and death in clinical ethics.

In this paper, we aim to identify some of the common default positions and their associated burdens of justification in clinical ethics. The positions are obviously commonly recognized and broadly operational in most clinical settings—that's partly what makes them default positions rather than mere 'rules of thumb' or heuristics. Identifying default positions and describing their default status in clinical ethics consultation is useful for at least three reasons. First, it can help to economize decision-making and the resources that help to facilitate ethical decision-making. Second, identifying the adopted default positions and their associated burdens of justification illuminates the values that medicine actually adopts, perhaps too easily and to the detriment of patients' well-being. Identifying the epistemic requirements to overturn these defaults reveals what medicine and clinical ethics actually value. Third, understanding the various default positions is beneficial in teaching medical trainees in both the practical application of ethical decision-making, and the foundational moral assumptions the defaults imply about the profession of medicine.

The next section introduces our notion of a default position and then identifies some of the more common default positions and their respective epistemic requirements to overturn. There are certainly other default positions and there are multiple ways these might be catalogued and evaluated. But we do so initially according to the values that the default positions appear to promote and protect. The section that follows begins to extrapolate from this catalogue and identifies the fundamental value that these burdens tend to promote and protect. Unsurprisingly, avoiding significant harm tends to be the aim of many default positions. We conclude the paper with a discussion of the implications of default positions, including the disvalue they may engender.

2. Default Positions

2.1 What they are

Default positions are accepted patterns of practice that will be adopted in the absence of countervailing reasons not to adopt that position. Some default positions

may be widely accepted, but nevertheless be poorly justified.¹ Such positions might achieve default status simply by convention, or because “that’s just how things are done.” For example, it may be the default position at an institution that capacity assessments are to be conducted by psychiatrists (as it was at our institution). This is a poorly justified pattern of clinical practice established by convention (at our institution; at other institutions it may be well justified). Other positions might achieve default status after careful consideration and deliberation. For example, there is fairly strong justification for the idea that by default a patient should be presumed to be capable of making their own medical decisions. Others default positions may arise out of consensus, which may or may not involve careful thinking or robust evidence. But even consensus is unnecessary for a position to become default. Their contents develop organically from a variety of factors, some of which may be particular to the local context. Default positions may arise out of moral reasoning or state, local, and institutional policy, but they need not. Why default positions exist, where they originated, and what justifies their existence is less important to this paper than the fact that they do exist and are used, consciously or unconsciously, in clinical ethics.

Default positions share some, but not all, features with standards of care or clinical practice guidelines in medicine. Standards of care and clinical practice guidelines guide action, are widely accepted, and, in the case of clinical practice guidelines, are not so binding that countervailing reasons can’t overturn them (standards of care, unlike clinical practice guidelines and default positions in clinical ethics, establish minimally acceptable action and cannot be overturned).

¹ Here we use the common epistemological use of ‘justify’ and its relatives. As such, a reason is not a justification, as sometimes one’s reasons don’t justify claims. To say that a position is justified is not to say that there are reasons for it; it is to say that there are sufficient reasons to hold it. Often laypeople use ‘justification’ as equivalent to ‘has reasons.’ But this use is inaccurate and imprecise, as it ignores the point that ‘justification’ has normative implications. If one has justification to believe something, they should believe it. But it’s false that one should believe something, if they have reasons for it. Those reasons might be insufficient. This not an idiosyncratic, overly technical, or otherwise unconventional or problematic use of ‘justify.’ Rather, it is the prevailing use of the term in epistemology, specifically, and philosophy, more generally. Thanks to an anonymous referee for bringing to attention the need for this clarification.

The *justification* for (rather than content of) a default position might also arise from various sources. A position's status as default may arise out of moral, epistemic, or legal reasoning. Or it may arise simply out of moral intuition—a position is default because that position seems right—or because over the course of time it has offered 'better' outcomes. Regardless of how a default position is justified, if it is at all, that justification is—at best—merely *prima facie*. To say that a default position enjoys *prima facie* justification is to say that in the absence of countervailing reasons or evidence, there are minimally sufficient grounds to hold that position. Other considerations may override that justification. Of course, sometimes there is no identifiable justification for default positions, but they have arisen out of convention.

Equally important as identifying what default positions are is identifying what they are not. Default positions need not be true, all-things-considered justified, a matter of consensus or expert opinion, or derived from sound reasoning. And default positions themselves are not equivalent with intuitions or “knee-jerk” reactions to a situation, even though they may originate with them.

Dien Ho (2016) argues that the “Default Principle” operates in clinical ethics and represents a *tool* for deliberation. The principle, according to Ho, justifies the clinical ethicist in issuing recommendations, even if moral anti-realism or moral skepticism are true. The Default Principle, for Ho, operates only in the context of asymmetric moral conflict, which is just a conflict between two moral claims that fail to enjoy the same reasons. In such contexts, the Default Principle is that “A is permitted to do X unless B justifies why A is not permitted to X.” In other words, in situations of asymmetric moral conflict, the justification for action defaults to autonomy, unless those who oppose such action can defeat that justification.

There are several important differences between Ho's use of the Default Principle and our use of the default positions in clinical ethics.

First, Ho claims that the Default Principle is value-neutral, that it can be used regardless of the metaphysics of morality (though whether this is true is arguable; a precondition on its use is that one adopt autonomy as a value worth promoting, which is anything but value-neutral (Brummett and Ostertag, 2018)). On our view *default*

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

positions depend on the adoption of values not only for their generation but also in determining the degree to which one must provide reasons to overturn them.

Second, Ho's principle only works in the context of disagreement; it's a tool for deliberation about what to do when there are asymmetrically conflicting options. In our view, default positions are what they are, and they influence decision-making regardless of whether a conflict is present, whether other available options asymmetrically conflict, or even whether there are other available options at all.

Third, Ho's principle is explicitly an attempt at resolving debates in clinical ethics about the implications of metaethics for ethics expertise and the nature of the recommendations that clinical ethicists make. But for us, these debates are irrelevant. Our claims are that default positions operate in clinical ethics consultation practice, that they reflect, reinforce, or deprioritize certain values, and that the function of default positions have important implications for their associated epistemic properties, such as how much and what quality of evidence their rejection demands. Whereas Ho's principle is situated squarely in the center of debates on clinical ethics expertise, those debates are, at most, tangential to our claims.²

Fourth, Ho's account relies, almost exclusively, on the supremacy of the value of autonomy. On our view, default positions reflect the adoption of a range of values, namely respect of persons, utility, and justice. Thus, the range of moral values that fall within the scope of our account is quite a bit wider.

² This is not to say that how our account of default positions and their role in clinical ethics interacts with these debates is uninteresting or unimportant. Indeed, the recent debate in this journal between Brummett and Watson (2022a, 2022b) and Fiester (2022) about ethics recommendations and their contents may suggest that this debate would be advanced if it were to incorporate our view of default positions. And although we generally don't find consensus to carry any kind of normative weight (Crutchfield 2019) organizations that attempt to achieve consensus, such as the American Society for Bioethics and Humanities, may start the clinical consensus-building process with these defaults. More relevant for the present purpose is that, for this article, we remain neutral on both the metaethics that ground various claims regarding ethics expertise as well as the nature of the representational content of the clinical recommendations that clinical ethicists issue. If anything, incorporating our account of default positions may advance this debate. But we simply cannot engage in that project here.

Fifth, and perhaps most importantly, Ho's account is primarily prescriptive, whereas our account is primarily descriptive. Ho's account is supposed to *prescribe* how to deliberate in the context of conflict, specifically conflict surrounding the legitimacy of clinical ethics consultation recommendations and expertise. Instead, we *describe* a range of default positions and their epistemic implications.

In short, compared to our account, Ho's account is different in kind, narrower in scope, and intended to serve a different function in clinical ethics. Other than acknowledging that another author uses a term that we use and differentiating that use from the present use, further consideration of Ho's account is orthogonal to our account. Thus, we leave it here.

The features of default positions *that are relevant* here are that they are widely adopted action-guiding defeasible positions. They promote and protect values, but their doing so need not be justified or even justifiable. Even though they promote and protect values, the normative weight of the default position—the strength of its prescription—may be strong or weak. We say more about this later, but, for example, that a person ought not cause harm to another person is a position that carries significant normative weight and thus implies a strong prescription. Some default positions may be normatively weightier than others. Satisfying the obligation to not harm often, but not always, overrides other prescriptions. Indeed, much of what follows is tying the moral normative weight (the strength of its moral prescription) to the epistemic normative weight (the strength of its epistemic prescription, which may be determined by one's epistemic obligation to hold a certain belief, as determined by, for example, the evidence one has in support of the belief; more evidence may imply a stronger obligation to believe).³ But by their very nature, default positions are never so (morally or epistemically) weighty that other considerations can't overcome them. Default positions are inherently defeasible.

Default positions, and how they operate in medical decision-making, are also importantly different from other aspects of bioethical reasoning. In particular, they are

³ The difference between moral normative weight and epistemic normative weight is that moral normativity prescribes conduct related to moral properties and epistemic normativity prescribes conduct related to epistemic properties.

distinct from the moral justification for the role of specific values central to biomedical ethics. Though we claim that default positions protect respect for persons, utility, justice, and, ultimately, harm avoidance, and these values are central to principlism, (Beauchamp and Childress 2013), there are significant differences between our account of default positions and principlist reasoning.⁴ The primary difference is that default positions are merely descriptive (though they may have implications for other epistemic or moral prescriptions), while principlism provides the moral reasoning that is supposed to justify the centrality of the four principles to biomedical ethics (e.g., we *should* think that autonomy is so important because of common morality...). We are not offering a moral theory, or a justification for which values are important or preeminent, nor how they should be operationalized in bioethical decision-making. Second, for principlism, decision-making proceeds from explicit consideration of these values, while on our account default positions influence decision-making independent of consideration of the values that the default positions promote. Default positions shape deliberation and decision-making regardless of whether one recognizes, or even supports, the specific values that the default positions promote and protect.

Third, default positions exist independent of any moral theory of bioethical reasoning. Default positions are not conditioned upon any specific moral framework, nor tied to individual accounts of moral values. One can recognize default positions and their role in decision-making even if one discounts the values they protect and promote, or even if one thinks that there is no such thing as morality (but, of course, that person would reject that default positions serve to protect and promote moral values).

Fourth, default positions may develop organically and implicitly, not exclusively by explicit moral reasoning. Moral theory may contribute to the development of defaults, but default positions need not be predicated on moral theory. Defaults are also not moral intuitions, or “knee-jerk” reactions to a situation, though intuitions and knee-jerk

⁴ We introduce principlism only because there is overlap in the relevant values central to the respective analyses. There are many fine accounts of the moral foundation of applied ethics generally, and medical ethics, specifically. The present account is neutral on the various moral theories that may ground applied ethics.

reactions may be causally relevant in the development of default positions. Rather, a variety of factors may contribute to their development, such as the attitudes of patients and clinicians, shifting social dynamics, applicable laws, journal articles, and even local conventions. For example, a local default position is that the psychiatry team is consulted when a patient needs a decision-making capacity assessment. This is a default position that is local, though other locales may feature the same default. It is not a default position of psychiatry or hospital medicine or academic medicine; and it is not a default position by law or hospital policy. Rather, it is a default position that has developed organically over many years in a community. A variety of social, institutional, legal, and moral factors have gone into its development and local practice and training reinforce the default position that psychiatrists perform capacity assessments.

Default positions may additionally enjoy widespread acceptance, but widespread acceptance of a practice or custom does not necessarily generate default status. Even when positions become the default position, it may still be the case that there is a diversity of opinion regarding the matter. For example, one default position we identify is that (in the U.S.) a person is not an organ donor (the U.S. is “opt-in” for organ donation). The fact that many people, even the majority of people in a community want to be organ donors doesn’t undermine the position’s default status. Further, given the variety of ways in which a default position may originate, it is possible that two communities may adopt opposite and contradictory default positions. While it’s not possible in such circumstances for both positions to be true, it is possible that people in those communities are equally confident in their positions. For example, it would be nonsensical for a community to simultaneously hold the default positions that all persons are organ donors and are not donors. Either a community or jurisdiction can take an “opt-in” or “opt-out” approach to organ donation, but not both at the same time. Even so, these possibilities do not threaten the forthcoming analysis, for we are presently concerned with how default positions—whatever their contents and origin—function in decision-making. In other words, the fact that some people may make a decision that is in conflict with a given default position does not imply that that position is not a default. Default positions are *starting points*, not ending points.

Principlism holds that the values are foundational to medical decision-making, but that other factors can help to specify their application. We are not claiming that default positions act the same way. Rather, the content of default positions develops from a variety of factors, some of which may be specific to the context. Once that content develops, default positions shape decision-making by, for examples, anchoring cognitive processes, setting a baseline decision, and influencing deliberation among team members. Likely, default positions may promote unreflective and careless thinking and decision-making. But this influence is significant. That a position is a default position is often determinative.

We are thus primarily concerned with identifying common default positions in clinical ethics, the values that they promote and protect, and the epistemic requirements to overturn them. We are not concerned with the moral theory that goes into their development. We think that a robust examination of default positions serves to illuminate common practices in clinical ethics and some of the moral implications of these practices. It is not an exhaustive catalogue of all default positions in clinical ethics, but our analysis, we think, can apply to any default position one encounters.

2.2 Respect for persons

Many of the default positions and their associated burdens of justification function to protect the value of respect for persons. We take this value to include respect for a person's preferences and promotion of autonomous decision-making.⁵ Such respect obviously has a long and important history in biomedical ethics.(Beauchamp and Childress 2013) We don't make any claim here about the proper role of respect for persons or the implications its promotion has for clinical practice. We do claim, however, that the default positions protect it. Common default positions that protect the value of respect for persons include the following:

- A person is capable of making their own medical decisions;
- The last known capably expressed preferences guide decisions;

⁵ Recall that Ho's Default Principle is a default to promoting autonomy.

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

- An advance directive is a legitimately executed documentation of patient preferences;
- A person is not a danger to himself or others;
- A person is not an organ donor (in some countries)

For all of these default positions, the burden of justification rests with the person wishing to overturn the default position. In other words, the person who asserts that a patient is not capable of making their own medical decision bears the burden of proving the facts of the position. But the strength and quality of the evidence required to overturn a default position varies. Because there are so many different default positions and the strength and quality of evidence needed to overturn them varies so much, we cannot go into a detailed analysis of each of these differences here. This is a practical and logistical limitation, not a theoretical or conceptual one. An exhaustive list of default positions in clinical ethics could be created, and probably should be, but it would be a book-length project and is ill-suited to a journal article and its concomitant space limits. However, we observe here in this journal article that the epistemic requirement to revoke a person's ability to make their own medical decisions (psychological or legal) is quite high. Meeting the requirement in these cases often requires multiple independent assessments that the person cannot (psychologically or legally) make medical decisions for themselves.

By contrast, the epistemic requirements to overturn the default position that a person is not an organ donor is likely to be relatively low. Surrogate testimony or, in some jurisdictions, even speculation that the donor would not object to organ donation is often sufficient. The epistemic requirements to overturning the default position that the last known capably expressed preferences guide decisions are perhaps somewhere in between—not as high as the burden to revoke decisional authority from a patient but higher than the burden to allow organ donation. To overturn the default position that the last known capably expressed preferences should guide treatment decisions, one may rely simply on surrogate testimony. But the quality of testimonial evidence required will vary according to the reliability of the last known capably expressed preference (e.g., by its recency) and the reliability of the person providing testimony.

2.3 Utility

Some of the default positions are clearly a matter of respect for persons. But there are other default positions that promote or protect other values. That they promote or protect other values does not imply that they don't also promote or protect respect for persons. The following default positions promote utility, but that does not mean that they do not also promote or protect respect for persons.

- A person is an organ donor (in some countries);
- A parent makes decisions in the best interests of their child;
- A person wants CPR in the event they go into cardiac arrest;
- Escalation of medically appropriate treatment is compatible with patient preferences;
- A surrogate is legally and psychologically able to make medical decisions;
- A surrogate is who they claim to be;
- A surrogate has no financial conflict of interest with the patient;
- A surrogate cannot refuse pain medications on behalf of the patient;

Like the default positions that protect respect for persons, these default positions have varying epistemic requirements to flip them.

One of the most common default positions is that a person wants to live longer and live "better." Thus, physicians frequently default to escalating treatment to pursue longer and better life, under the presumption that this is compatible with patient preferences. Thus, even if the specific preferences of a patient are unknown or if the patient otherwise lacks decisional capacity, the medical staff may often default to the position that treatment necessary to extend and improve life aligns with the patient's preferences and is medically appropriate. This default is often difficult to overturn. Suppose a decisionally incapable patient is refusing a life- or limb-saving treatment. The default position may likely be to proceed with the treatment over the patient's incapable objection. To overcome this default, high quality evidence, either from a surrogate decision-maker or an advance directive, would generally be necessary to meet the burden. This evidence would need to either testify to the patient's capacity to refuse or

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

to their last known capably expressed preferences. Even then, it may not be sufficient to overturn the default to treat the patient such that they live longer and better.

The default position that comes with the highest epistemic requirement to overturn, perhaps in all of clinical ethics, may be that a parent makes decisions in the best interests of their child.⁶ To meet this burden, one would need to provide quality evidence either that the parent fails at determining their child's best interests or that their decisions regarding their child fall short of the child's best interests. Collecting this evidence is challenging, especially since it requires a historical perspective of that particular parent-child relationship, which is a perspective uncommon to the episodic and intermittent encounters with the parent and the child.

The default positions that a surrogate cannot refuse pain medications on behalf of a patient and that escalation of medically appropriate treatment is compatible with patient preferences also carry heavy epistemic requirements to overturn. A surrogate wanting to withhold pain medicine from a patient for whom such drugs would be beneficial must provide high quality evidence that the patient would not want such drugs, or that providing them would otherwise undermine the patient's interests. In the absence of such evidence, the presumption that the patient would want to be free of pain may stand. Similarly, unless there is excellent evidence to the contrary, the default is that one's interests are best served by escalated treatment, should such escalation become indicated to save life or limb.

But not all defaults that promote utility are difficult to overturn. The involvement of a surrogate decision-maker promotes the utility associated with having one's interests and preferences satisfied. But the default positions associated with surrogate decision-making generally carry low burdens of justification. For example, the epistemic

⁶ This default usefully distinguishes between the moral justification for positions in clinical ethics and their status as a default position. Recently, some authors have argued that the best interest standard for pediatric decision-making is less appropriate than other standards (Diekema 2019; Ross 2019). Our point is that even if these moral arguments succeed in establishing (we aren't saying whether they are or aren't), the moral arguments don't change the fact that people typically default to the best interest standard, a fact which the opponents of the best interest standard recognize (Diekema 2011). They do so even if the best interest standard doesn't have good moral reasons to think it is true or to use it in clinical decision-making.

requirements to deem a surrogate unqualified to make medical decisions on behalf of a patient are much lower than those associated with deeming the patient unqualified to make their own medical decisions.

2.4 Justice

There are additionally some default positions in medicine that promote justice or fairness (though they may also simultaneously promote utility or respect for persons). The most salient of these now may be the default position that one must be vaccinated against infectious diseases. In the absence of a good reasons to be exempted from this requirement, one must satisfy a significant epistemic requirement. Meeting this burden often requires that one sincerely objects or that the vaccine is medically contraindicated. Typically, this is not an epistemic requirement that can be met with mere testimony—one must submit evidence in writing, and even then it may not be enough to meet the lofty requirement, in which case they may still be required to receive the vaccine.

Though the epistemic requirements to overcome the default position that one ought to be vaccinated are high, there are other default positions that promote and protect justice:

- That an emergency room cannot refuse to see a patient;
- That race is irrelevant to medical recommendations;
- When resources are abundant, they are allocated based on first-come, first-served;
- That physicians should not withhold treatments based on judgments of the patient's actions.

As in the cases of respect for persons and utility, the epistemic requirements to overcome these default position may vary between them. But we note here that in all of these cases, the default positions may be extremely difficult to overturn. For example, there are cases in which race can be relevant to medical recommendations, but to overturn the default one must show evidence that doing so is part of good medicine, such as by providing scientific evidence that race matters. Similarly, to allocate

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

abundant resources in some way other than first-come, first-served one must provide evidence that a person should jump the line. The evidence required for this re-ordering of allocation may be the medical judgment that the person nearer the back of the line has a greater medical need than the person in front of them. These are ordinary, everyday decisions in medicine, but they are backed by evidence. Other things being equal, the first person gets the resources, and it is very difficult to overturn this default.

By default, physicians should not withhold treatment decisions based on their judgment of the patient's actions, or how deserving the patient is. Even if a physician discovers prior to treatment that the patient is, for example, a serial killer, they are still obligated to provide treatment. The evidence necessary to overturn this default position would have to be such that it supports some stronger obligation. It would have to, for instance, provide compelling reasons to think that, if treated, the person will kill again or that any treatment conflicts with one's other interests or commitments.

3. Burdens and Values

These default positions are not the only default positions in clinical ethics, but they are default positions that healthcare providers and ethicists commonly encounter. To our knowledge, there are no data on the prevalence of various default positions. Moreover, it would be impossible to fully catalogue all of the default positions that exist in clinical ethics. Rather, these are the more salient default positions that most clinical ethicists will easily recognize. The preceding discussion of defaults can be a useful guide to responding to those cases in which these positions influence decision-making, even without awareness or concern for the values that the default positions protect and promote, which is what this section addresses.

In this section, we draw attention to some general considerations about the values associated with default positions. We do not attempt to provide a complete ethical analysis of each of these default positions.

Not all of the default positions protect or promote respect for persons and not all of them protect or promote utility and not all of them protect or promote justice. But all of

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

them do seem to protect or promote one of these. This is not particularly illuminating, as these are fundamental moral values in modern healthcare.

What is perhaps more illuminating—and more useful—is that the different default positions have different epistemic standards to overturn. For example, the evidence required to overturn the default that a person is capable of making their own decisions must be of much greater quality (e.g., multiple formal capacity assessments) than the evidence required to overturn a default position that a surrogate is capable of making surrogate medical decisions. Recognizing this point is useful, because doing so *invites an explanation*, which may then be used to adjudicate conflicts.

There may be multiple explanations for why different default positions carry different epistemic requirements to overturn them. One starting point for an explanation for the differences in epistemic requirements is the simple observation that the default positions generally serve to avoid significant harm. Although all the default positions appear to protect or promote respect for persons, utility, or justice, at a more fundamental level all of the default positions seem biased toward avoiding significant harm. For example, one of the greatest harms a person can experience is having their authority to make their own decisions regarding their treatment be unjustifiably undermined—being denied the right or ability to make one's own decisions diminishes one's well-being (which may be why the one default position that Ho identifies protects autonomy). If the purpose of default positions is to bias decision-making such that harm is more likely avoided, then we should expect the default position to be what it is, and we should expect that the epistemic requirements to overturn it to be very high, which they are.

Those default positions with lofty epistemic requirements to overturn seem to avoid significant harms. And those default positions with lower epistemic requirements to overturn avoid lesser harms. The epistemic requirements to overturn the default position that a person is not an organ donor are often low. The harm that this default position helps to avoid is often minimal. The donor is deceased anyway, which means that procuring their organs does not make them significantly worse off than they otherwise would be (presuming a comparative account of harm).

In revoking a person's authority to make their own medical decisions, the stakes are high. In the case of overturning the default position of a person's organ donation status,

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

the stakes (for the patient) are low. The epistemic requirements of overturning these default positions corresponds to the stakes. In removing a parent as their child's decision-maker, the stakes are high. The stakes are also high in withholding beneficial pain medicine at the request of a surrogate. The stakes are (usually) low in disqualifying a surrogate decision-maker for an adult patient.

Thus, one plausible account of variable epistemic requirements is that they do so according to the stakes. Such an account would not be surprising, as a plausible account of justification and knowledge is that the standards for these epistemic properties rise and fall with the stakes. (Cohen 1999; 2000; Stanley 2005) That is, the standards for justification and knowledge go up and down relative to the context, and the relevant feature of the context is what's at stake. In the case of the default positions identified here, it may be the same phenomenon that operates on the epistemic requirements to overturn a default—as potential for significant harm (i.e., the stakes) goes up, so do the epistemic requirements. Thus, as one confronts the need for evidence in clinical ethics, especially in overturning default positions, identifying the stakes, or the potential for harm, can help to identify the epistemic requirements needed to establish the target position.

This account of default positions also helps to explain why the default positions promoting or protecting justice may be so difficult to overturn. Simply, if there were no such default positions regarding emergency medicine, integrating race into medical recommendations, or the appropriateness of judging whether a patient deserves treatment, many people, not just the patient, would be harmed, and likely to a significant degree. The default positions that promote and protect justice have such high epistemic requirements to overturn because the stakes of not having these default positions are so high. To be exempted for vaccine requirements for oneself or one's children one must often satisfy significant epistemic requirements. Our claim is that, at bottom, this is due to the fact that the stakes of not getting vaccinated are so high, not only for oneself or one's children, but for many other people.

Earlier we note that the default positions may vary in the normative weight they carry. We can now elaborate on the relative normative weight of the different default positions. The normative weight of a particular default position—the degree to which it

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

prescribes right action—may be primarily a function of the harm it aims to reduce or prevent. When two default positions are balanced against each other, the default position with greater normative weight will be a matter of how much harm they aim to reduce or prevent.

Given that normative weight is a matter of degree of harm reduction and prevention, it should be no surprise that the default positions that promote or protect justice may outweigh those that promote or protect other values. The default positions promoting and protecting justice may aim to reduce or prevent much more harm than the default positions promoting or protecting other values. This is not to say that the other default positions fail to aim to reduce or prevent harm to people other than the patient, just that the degree to which they may do so is much lower than the degree to which the default positions that promote or protect justice do so.

The default positions listed here are widespread. But our analysis also explains local defaults. Consider the local default position that all capacity assessments be conducted by a psychiatrist. This default position is supposed to protect respect for persons and, ultimately, avoid the harm associated with disallowing someone to make their own medical decisions. The default position avoids this harm because it is supposed to make it more likely that a capacity assessment will be accurate and that all and only those without decisional capacity will be disallowed from making their own medical decisions. The default being what it is, those interested in overturning the default bear the burden of evidence. Specifically, the local psychiatrists routinely push back against the default. And when they do, they bring to bear evidence. This evidence includes claims related to the practice of medicine (e.g., psychiatrists do not necessarily do a better job; capacity assessments are well within the scope of practice for any licensed physician) and claims related to the law (there is no state or local law requiring psychiatrists to perform capacity assessments). The most effective argument that resulted in change to the local default was the argument that the practice created harms due to delays in assessment, undermining the argument that the default practice promoted utility through increased efficiency.

We have identified some of the most prevalent default positions and some of their associated burdens of justification. But there are undoubtedly more throughout medicine

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

and clinical ethics. If it is right that epistemic requirements to overturn these default positions rise and fall with the potential for significant harm, then we should expect the same out of these other defaults. Thus, where there is uncertainty, disagreement, or *prima facie* ambiguity regarding who bears the burden of justification or what they must do to meet that burden, if the potential for significant harm can be identified, then so can the burden of justification and its associated epistemic requirements. If the stakes are high, then the person bearing the burden of justification must meet high epistemic requirements. If the stakes are low, then the burden may be met by low quality evidence.

4. Dangers of Default Positions

Default positions promote and protect moral values, primarily the respect for persons, utility promotion, justice, and, more fundamentally, harm avoidance. But sometimes these default positions, through this protection and promotion, can actually undermine these values. For example, adherence to the default position that a parent makes decisions according to their child's best interests can potentially disrespect the pediatric patient. Pediatric patients' preferences still have moral value, even if they aren't fully capable of making medical decisions.(Navin and Wasserman 2019) This value stems from their personhood. If the child's morally valuable but incapably expressed preference conflicts with the parent's account of their best interests, then the conflict will default to the parent and the child will be treated contrary to their preferences, which disrespects them.

This reasoning applies to other instances in which a person has morally valuable preferences but is non-rational. Another example of this overly strong default protection of the rational decision-making associated with respect for persons is when a patient lacks the capacity to make medical decisions but nevertheless has morally valuable preferences to appoint a surrogate decision-maker, such as a person with moderate dementia.(Wasserman and Navin 2018) For such a person the epistemic requirements of flipping the default may be too heavy for them to meet and the staff may then

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

disregard the patient's preference for surrogate. This in turn disrespects them and harms them.

In cases like these, the problem stems from the default protection of rational decision-making associated with respect for persons when there are other morally valuable sub-rational preferences that one might express. This puts patients who have a capacity for preferences but not full decisional capacity at risk: children, psychiatric patients, or those with other decisional-capacity-undermining conditions.

Moreover, if the default position has been established merely on the basis of intuition or a 'knee jerk' response, and that default was pervasive and deeply rooted in the institutional practice, unreflective or uncritical application of a default position could be deleterious to the patient, their family, clinicians or society. For example, a default that a psychiatrist must make the capacity assessment combined with a psychiatrist who is unappreciative of the moral components of capacity may lead to that person may make the capacity assessment merely on the basis that the patient lacks a diagnosable mental illness.

Perhaps the default position that most endangers moral values is the default position that a person is not an organ donor (in some countries). The default position may protect against harming the potential donor and promote their personhood. But adherence to the default position causes many people to die every year.(Davidai, Gilovich, and Ross 2012) These are people who, in the absence of the default position, may be more likely to continue living after a successful transplantation. And in continuing living, they are in a better position to have preferences worthy of respect and enjoy significant benefits. The default position squanders organ recipients' potential preferences worthy of respect and untold individual and societal utility. In return, patients and families and physicians receive assurance that an otherwise potential donor patient's preferences to not donate will not be violated, even when, as usual, there is uncertainty regarding whether that patient actually holds that preference. Overall, the default position implies a net loss of respect-worthy preferences. This is a significant moral cost.

The default positions may be morally justified, in general (and they may not be morally justified—whether they are justified is, again, not the point). But this doesn't

imply that adherence to them doesn't have moral costs. There are also epistemic costs in meeting the epistemic requirements to overturn the default positions. Some of these costs may be more than a person is able to pay. A surrogate may know that a patient has changed her mind since her last advance directive, but not be able to provide sufficient evidence for that changed preference. A physician may have a high degree of certainty that a patient will never meaningfully recover brain function, but not be able to produce sufficient evidence if the patient is not quite dead by neurological criteria. The default positions imply these epistemic obstacles and the failure to overcome them makes moral disvalue more likely. Thus, even when there is insufficient evidence to meet the burden of justification associated with a particular default position, one should still be epistemically cautious in their consideration of default positions.

5. Conclusion

Default positions, as we have described here, act as epistemic shields from undermining respect for persons, utility, justice and, more fundamentally, the prevention of harm. All default positions imply epistemic requirements. However, some may think that in medical decision-making, every decision should be made simply based on what reasons one has, that default positions have no place in such decisions. (Koplin and Selgelid 2015) For example, one may assert that there should be no default position regarding the qualifications of a surrogate decision-maker. Whether a particular surrogate decision-maker is qualified should be determined on a case-by-case basis. On this view a surrogate decision-maker can only be deemed qualified if one has positive reasons to believe that the individual meets the qualification standards (i.e., decisionally capable, legally authorized, capable and willing to substitute judgment and decide in accordance with the patient's best interests). The same is true for any position one might take—one must have positive reasons for that position rather than default to a particular position.

There are a number of problems with this rejection of default positions. First, default positions protect against undermining moral values, even if we are wrong about which values they protect. In the absence of default positions, there is less protection of these

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

values or any others. The absence of default positions makes achieving value less likely, which is bad.

Second, default positions serve another important function. They conserve decisional resources in the provision of medicine. Decision-makers, either those on the medical staff, patients, or surrogates, do not have infinite, or even particularly deep, wells of decision-making resources. Making medical decisions, especially those with high stakes, is cognitively, physically, and emotionally taxing. Furthermore, people have other things to do, and these other things, however irrelevant to the decision, still intrude upon decision-making. Default positions help to prevent this intrusion, because where there is a default position one doesn't need to carefully weigh reasons. And default positions conserve resources as one moves through the many decisions one must make so that these resources can be expended on other decisions. For example, a surrogate decision-maker may be able to devote more resources to the decision about whether grandpa would or would not want to remain on a ventilator for the long-term if they don't also have to first show identification and formally demonstrate decisional capacity. And the nurses and physicians caring for grandpa may devote more time to other treatments and decisions if they don't have to verify the surrogate's identity and perform a capacity assessment on them.

Third, if having positive reasons, rather than relying on a default position, is a necessary condition on medical decision-making, then we must hold this need for positive reasons to the same standard. One must have an answer to the question, "What is the reason for accepting this reason?" Whatever one's answer, one must then support it with positive reasons. And so on *ad infinitum*. Claims and decisions need firmer foundation than this. (Fantl 2003; Klein 2005) Default positions prevent this infinite regress.

Given that default positions seem to be so pervasive throughout clinical ethics, the profession may respond in several ways. One response is for clinical ethics training programs to include training and education on some of the cognitive processes involved in decision-making, including training and education in identifying default positions and the values that those positions serve. Further, all clinical ethicists should reflect upon the causal process that results in their recommendation, noting whether that

Penultimate draft forthcoming in *Journal of Clinical Ethics*. Please cite final version

recommendation started with a default position and whether the evidence they possess is sufficient to overturn that position.

Declarations

The authors declare that they have no conflicts of interest or commitment.

References

- Beauchamp, T L, and J F Childress. 2013. *Principles of Biomedical Ethics*. OUP USA. <https://books.google.com/books?id=I9VIMQEACAAJ>
- Brummett, A. L., & Watson, J. C. (2022a). "An Argument for Standardized Ethical Directives for Secular Healthcare Services." *The Journal of Clinical Ethics*, 33(3), 175–188. <https://doi.org/10.1086/JCE2022333175>
- Brummett, A. L., & Watson, J. C. (2022b). "Responding to Fiester's Critique of a Bioethical Consensus Project." *The Journal of Clinical Ethics*, 33(3), 198–201. <https://doi.org/10.1086/JCE2022333198>
- Brummett, A., & Ostertag, C. J. (2018). Two Troubling Trends in the Conversation Over Whether Clinical Ethics Consultants Have Ethics Expertise. *HEC Forum*, 30(2), 157–169. <https://doi.org/10.1007/s10730-017-9321-8>
- Clark, Andy. 2013. "Whatever next? Predictive Brains, Situated Agents, and the Future of Cognitive Science." *Behavioral and Brain Sciences* 36 (03): 181–204. <https://doi.org/10.1017/S0140525X12000477>.
- Cohen, Stewart. 1999. "Contextualism, Skepticism, and the Structure of Reasons." *Philosophical Perspectives* 13: 57–89.
- . 2000. "Contextualism and Skepticism." *Philosophical Issues* 10: 94–107.
- Crutchfield, P. (2019). Moral Normative Force and Clinical Ethics Expertise. *American Journal of Bioethics*, 19(11). <https://doi.org/10.1080/15265161.2019.1665733>
- Davidai, Shai, Thomas Gilovich, and Lee D Ross. 2012. "The Meaning of Default Options for Potential Organ Donors." *Proceedings of the National Academy of Sciences* 109 (38): 15201–5.
- Diekema, Douglas S. 2011. "Revisiting the Best Interest Standard: Uses and Misuses." *The Journal of Clinical Ethics* 22 (2): 128–33. <http://europepmc.org/abstract/MED/21837884>.
- . 2019. "Decision Making on Behalf of Children: Understanding the Role of the Harm Principle." *The Journal of Clinical Ethics* 30 (3): 207–12. <http://europepmc.org/abstract/MED/31573963>.
- Fantl, Jeremy. 2003. "Modest Informatism." *Canadian Journal of Philosophy* 33 (4): 537–62.

- Fiester, A. (2022). "Values Imposition and Ethical Pluralism: An Argument Against Standardized Ethical Directives for Healthcare Ethics Consultants." *The Journal of Clinical Ethics*, 33(3), 189–197. <https://doi.org/10.1086/JCE2022333189>
- Hart, Joanna, and Scott D Halpern. 2014. "Default Options in the ICU: Widely Used but Insufficiently Understood." *Current Opinion in Critical Care* 20 (6): 662–67. <https://doi.org/10.1097/MCC.000000000000146>.
- Ho, D. (2016). "Keeping it ethically real." *Journal of Medicine and Philosophy (United Kingdom)*, 41(4), 369–383. <https://doi.org/10.1093/jmp/jhw010>
- Hohwy, J. 2013. *The Predictive Mind*. OUP Oxford. <https://books.google.com/books?id=5QD2AQAAQBAJ>.
- Klein, Peter D. 2005. "Infinetism Is the Solution to the Epistemic Regress Problem." In *Contemporary Debates in Epistemology*, edited by Steup Matthias and Sosa Ernest. Blackwell.
- Koplin, Julian J, and Michael J Selgelid. 2015. "Burden of Proof in Bioethics." *Bioethics* 29 (9): 597–603.
- Navin, Mark Christopher, and Jason Adam Wasserman. 2019. "Capacity for Preferences and Pediatric Assent Implications for Pediatric Practice." *Hastings Center Report* 49 (1): 43–51. <https://doi.org/10.1002/hast.980>.
- Ross, Lainie Friedman. 2019. "Better than Best (Interest Standard) in Pediatric Decision Making." *The Journal of Clinical Ethics* 30 (3): 183–95. <http://europepmc.org/abstract/MED/31573960>.
- Stanley, Jason. 2005. *Knowledge and Practical Interests*. Clarendon Press.
- Wasserman, Jason Adam, and Mark Christopher Navin. 2018. "Capacity for Preferences: Respecting Patients with Compromised Decision-Making." *Hastings Center Report* 48 (3): 31–39. <https://doi.org/10.1002/hast.853>.