An Ethics Expertise for Clinical Ethics Consultation

Lisa M. Rasmussen
Department of Philosophy
University of North Carolina, Charlotte

A major obstacle to broad support of clinical ethics consultation (CEC) is suspicion regarding the nature of the moral expertise it claims to offer. The suspicion seems to be confirmed when the field fails to make its moral expertise explicit. In this vacuum, critics suggest the following:

(1) Clinical ethics consultation’s legitimacy depends on its ability to offer an expertise in moral matters.
(2) Expertise in moral matters is knowledge of a singular moral truth which applies to everyone.
(3) The claim that a clinical ethics consultant can offer knowledge of a singular moral truth in virtue of her professional training is absurd, false, or gravely immoral. Therefore,
(4) The field is illegitimate.

My aim is to articulate an expertise for clinical ethics consultation, which I call “ethics expertise” to distinguish it from a more robust, singular “moral expertise,” and to suggest that it avoids many of the problems critics cite. I forward the argument as a proposal for explaining and asserting the ethical expertise involved in clinical ethics consultation. In doing so, I accept premise (1), because to reject it would be to argue that CEC without a coherent, justified account of expertise in ethical matters would still be clinical ethics consultation. I reject (2), offering “ethics expertise” instead of “moral expertise” as a way of articulating the expertise in ethical matters that CEC can offer. I will also reject (3), because the “ethics expertise” I articulate is something that can be conveyed by training. My arguments should be understood as trying to carve out a conceptual space for the use of expertise on ethical matters in clinical ethics consultation which avoids serious critiques of moral expertise, merits the term “expertise,” and captures what clinical ethics consultants might do (and which some, though not all, consultants say they currently do or ought to do). I begin by distinguishing between “ethics expertise” and “moral expertise” as a way of distinguishing between the kinds of claims CECs might make, advocating the former and eschewing the latter.

I. Moral Expertise in Clinical Ethics Consultation

Expertise makes claims to authority plausible: unless there is a special area of knowledge or set of skills over which some but not all may claim mastery, there is no reason to deem some but not all authorities. What is that body of knowledge, or set of skills regarding
morality, which a clinical ethics consultant should command, without which someone would only fraudulently represent herself as a clinical ethics consultant? There is, after all, ambiguity in how moral expertise could be defined, so even if one holds that the professional legitimacy of CEC does depend on the existence of moral expertise, it is not clear on which definition it depends. For example, under a definition such as “facility with moral arguments,” moral expertise demonstrably does exist, but under a definition such as “possession of the moral truth,” it is highly contested, at least in a pluralistic, public forum. The dispute around moral expertise in clinical ethics consultation is in part due to a semantic ambiguity.

The blame for this ambiguity rests on the field itself, which has not adopted an official conception of the moral expertise it offers. This is not to say that CECs can define the problem away by stipulating a non-tendentious conception of “moral expertise” and claiming that that is what in fact CECs do. But nor may critics define the field away by stipulating a tendentious conception of moral expertise and claiming that this is what in fact CECs do. There is no canonical understanding of the term that would resolve these differences. Similarly, neither side may appeal to empirical evidence about the way in which “moral expertise” is interpreted by all CECs. To my knowledge this has not been attempted, and it would not be dispositive even if it were conducted. Nor can appeal be made to an officially sanctioned view of the definition and limits of moral expertise, because no such official body in clinical ethics consultation exists. The interest in certification, credentialing, licensing, accrediting, or in other ways formalizing clinical ethics consultation is partly motivated by the desire to establish what moral expertise in the field amounts to.

My aim is to demonstrate that a coherent expertise exists in regards to moral matters that can be deployed in clinical ethics consultation in beneficial (and non-absurd) ways. This is not to say that consultants will have an answer to every moral dilemma; indeed, the possibility and recognition of such lacunae, and how to progress in the face of them, must be addressed. However, consultants may be able to suggest solutions to a clinical ethics dilemma which do not resort to ideological coercion or abuse of authority. What is required to overcome opposition to CEC based on critiques of moral expertise is to present an account of moral expertise that avoids the main lines of objection, and to advocate its adoption by the field as a whole. This is a modest goal; if successful, it demonstrates only the possibility of a form of moral expertise that can be deployed in clinical ethics consultation. Though modest, it addresses some of the criticisms of the field.

To highlight the difference between the form of moral expertise I forward and the forms often assumed to be deployed in clinical ethics consultation, I would like to make a stipulative terminological distinction between “ethics expertise” and “moral expertise.” I do not mean to rest any conceptual weight on historical roots of the terms; I distinguish between the terms “ethics” and “morality” merely as a heuristic. By the term “ethics expertise,” I mean the ability to give non-normatively binding recommendations grounded in a pervasive ethos or practice within a particular context. Ethics expertise includes, among other things, command of the moral arguments behind applicable law; knowledge of academic consensus or dissensus on a particular question; knowledge of public sentiment on a particular issue when it has been compiled; and the historical moral foundations of clinical practice. For example, in the United States it would include
understanding that autonomous decision making is a central value, realized via informed consent; or that a woman’s right to an abortion, while morally contested, is based on her legal right to privacy; or that a certain percentage of the U.S. population indicate their willingness to donate organs after death. It also includes some knowledge about what particular religious groups may value, such as the refusal of blood and blood products by some Jehovah’s Witnesses or the desire of some Muslim women to be seen only by female physicians.

This expertise involves neither endorsement of the practices of others nor a blind deference to them. It requires that practitioners understand the milieu in which they operate, including local and federal law, institutional policy, demographics (e.g., what religions are represented in one’s local population), and when a situation requires that the consultant defer, or refer, to another authority (for example, a non-denominational chaplain practicing as a clinical ethics consultant should understand that a Catholic patient will require a Catholic priest to administer Confession, Communion, or Last Rites.) It also accommodates very different contexts, so that ethics expertise in one context would not necessarily translate to another context. As a result, American clinical ethics consultants would not necessarily be ethics experts in a Chinese clinical setting. It is even possible, using this term, to account for why a clinical ethics consultant in an American Catholic hospital needs different training and knowledge to be an ethics expert than would be required in an American public hospital: the context of each rests on different foundations. Most importantly, it warrants no claim to normatively binding knowledge. Knowledge of context merely supplies a set of considerations that may help a consultant work from a set of premises to a recommendation that is not obligatory but may prove helpful to a patient or family.

By “moral expertise,” which is not what I am arguing is possessed by clinical ethics consultants, I mean something more robust than ethics expertise. A moral expert in this sense could be understood to possess the ability to resolve dispute on a moral issue by rendering a decisive opinion. A priest, imam, or rabbi, for example, might be recognized as a moral expert by fellow believers, if he is understood to have a special access to God or the spiritual world. Because moral values and judgments vary significantly, moral expertise is not possessed by clinical ethics consultants merely in virtue of their professional training as CECs (though individuals could possess it incidentally in a particular situation, for example, if a Catholic priest acts as a CEC for a Catholic patient.)

In the main, what I am trying to achieve with these descriptions is a disavowal of any claims by clinical ethics consultants to some unique access to moral truth stemming from their professional role. In CEC, such claims should be met with frank skepticism, for a variety of reasons. However, the suggestion that there can be no ethics expertise in the absence of moral facts and recognized access to them simply poses a false dichotomy. There are facts about the world which can be known by some and not others, not because of a spiritual ability, but because of training and knowledge which can and should be rendered transparent to others. There are ethical judgments which can appeal to reasonable explanations that do not depend on adopting a mystical moral stance, and which merely result from the struggle to find an answer acceptable to the patient, family, or health care team in the midst of uncertainty. Think, for example, of a case where a terminally ill patient is considering refusing resuscitation in the event of cardiac arrest, which distresses a member of the health care team. The patient holds no specific
religious beliefs except a general belief that there is “something more than this life,” and is unsure whether or not refusing further treatment is appropriate, while the team member considers it morally obligatory for the patient to accept such life-sustaining treatment. A clinical ethics consultant can observe that the medical evidence suggests there is little to no chance of recovery, that resuscitation is invasive and painful, that many people, though not all, wish not to live in the condition likely to result from resuscitation, and that it is the patient’s legal right to determine what happens to him. A consultant can offer the opinion, in this case, that refusing resuscitation is among the reasonable options, and that the health care professional’s convictions are not to be decisive in such a case. At the same time, the consultant can observe that someone with different beliefs might make a different recommendation.13

Given the time it takes to become familiar with clinical contexts and the issues that often arise there, with options constrained by national, local, and institutional laws and policies, and informed by professional literature (in fields as diverse as moral philosophy, ethnography, sociology, psychology, etc.), it is reasonable to think that some individuals will be much more familiar with relevant facts than are others who have not spent much time considering those issues. Ethics expertise, then, is superior familiarity with context, which does not result in normatively binding recommendations. 14

Take the following case example:
A Chinese family is visiting the United States, when the mother falls ill and is admitted to the hospital. Examination reveals that she has advanced metastatic cancer. The attending physician is approached by the family and asked to discuss the mother’s diagnosis with them rather than with her, a practice distinctly at odds with common practice and the physician’s convictions. What should the physician do? 15

The tension in this case results from conflicting contexts: the family is integrated within a cultural context in which diagnoses may permissibly be withheld from individuals and revealed to families, yet the episode takes place in a particular context (a U.S. hospital) that normally requires the opposite. A clinical ethics consultant need not pronounce on which is morally obligatory in order justifiably to bear the title of an “ethics expert.” Instead, she can recommend an action by reference to a contextual justification. She can appeal to the fact that the American context is one in which it is exceedingly rare to withhold information from individuals about their own medical status for any reason, and never merely because a family requests it. However, she will also know that individuals are not obligated to hear the truth, and may elect to name a proxy decision maker. She may also know that within certain cultures, the default approach is as the family in this case has requested. Further, she may have read Benjamin Freedman’s “Offering Truth,”16 and thus recommend to the physician that he ask the woman whether she would like to know about her medical condition, as is common practice within this country, or instead to empower her family to make decisions on her behalf.

None of this requires extraordinary or mysterious expertise; each facet of the consultant’s decision can be made public and transparent. Yet this judgment is not based on knowledge that all can be expected to possess. A well-reasoned solution can be offered based on specialized knowledge that is not mystical or hierarchical. The beauty of Freedman’s solution in this case is that it is an elegant navigation of differing contexts in a way that attempts to respect both, and which can be understood by laypeople lacking
the consultant’s expertise. It must be noted that many, perhaps even most, such dilemmas will not be amenable to similarly creative approaches. However, it is an example of the kind of answer unlikely to occur to those unfamiliar with the considerable breadth of knowledge involved in clinical ethics, thus qualifying it for the designation of expertise. Ethics expertise is expertise about a variety of considerations that bear on a moral decision to be made. When a patient, family, or health care professional wants guidance on a moral matter, it is not usually that they want help disciplining themselves to do the right thing. For the most part, they are motivated to do the right thing, but because of the complexity of the situation, the right action is not clear. An ethics expert can help them to navigate the complexity — for example, by pointing out the distinction between empirical questions and normative questions, soliciting the relevant moral values, and helping to consider their implications. In this respect, a clinical ethics consultant serves as an expert ethics guide, drawing on a variety of fields of knowledge and offering recommendations, respecting the values of patients and medical professionals, and soliciting the aid of other experts where appropriate.

Before turning to the next section, it is worth considering other conceptions of ethics expertise that have been offered. In two early papers on the subject, Bruce Weinstein and Scott Yoder argue that such expertise depends on the ability to offer good justifications for one’s judgments. There are some general similarities between their articles and what I have proposed, and the models are likely compatible. However, my conception of ethics expertise is not centrally focused on a consultant’s ability to justify her recommendations, though we should probably expect that she should be able to do so. Instead, my aim is twofold: first, I discuss arguments against the notion of moral expertise in clinical ethics consultation and articulate a kind of expertise that is not subject to such critiques. Second, I argue that this conception of “ethics expertise” both merits the term and captures what many consultants consider themselves to be doing. In contrast to others who have addressed the notion of moral expertise in clinical ethics consultation, my focus is on the broad context of what expertise in clinical ethics consultation requires, and not on the narrower notion of what constitutes a moral fact. The point is to describe a realm of knowledge over which a consultant should have mastery, because it is from this entire realm that a consultant must draw in order to advise on clinical ethics consultations.

II. Arguments against Moral Expertise

Can morality be both something for which one is personally responsible and also something for which one may seek advice? How can there be experts in a field that has not come to much consensus in millennia? The notion of a robust moral expertise can just seem wrong, metaphysically, epistemologically, conceptually, and normatively. Defense of the claim that clinical ethics consultation offers an expertise in moral matters requires addressing these categories of objection. These objections are usually lodged against the idea of “moral expertise,” but it remains to be seen whether “ethics expertise” escapes the problems identified.

A. Metaphysical Arguments

Metaphysically, there is disagreement regarding the existence of moral facts. For example, moral realism is the metaethical position that moral statements (such as
“abortion is wrong”) can be true or false in virtue of some objective feature of the world. On the other hand, emotivism is the metaethical position that a moral statement cannot be true or false about the world, and is instead an utterance that merely communicates the speaker’s emotional attitude towards some aspect of the world. Metaphysical skepticism about moral facts entails skepticism about moral experts. If there are no moral facts, then no one can claim to know them, and there is therefore no basis for claiming expertise. To claim expertise about moral facts would thus be as mistaken as to claim expertise about the natural habitat or skeletal structure of unicorns.

How does “ethics expertise” fare against the metaphysical objection? Because it claims no objective knowledge about the metaphysical world, it is immune to a superficial aspect of the metaphysical critique. That is, it is unfounded to accuse ethics experts (under this definition) of making ungrounded metaphysical assertions, because they simply would not make such assertions. The deeper aspect of the metaphysical critique is that there cannot be ethics experts unless there are metaphysically grounded moral facts, and I reject this claim as posing a false dichotomy. I argue that there is an expertise whose subject matter consists of less than objectively true, metaphysically grounded facts about morality, mastery of which nevertheless warrants the attribution of the terms “ethics” and “expert.”

In the United States, the government established by the Constitution is not founded on a single moral metaphysics. Instead, citizens must struggle among competing views, and laws should allow as much latitude as possible for individuals to follow their own convictions. Clinical ethics consultation may provide some guidance for those who are unclear regarding the implications of their own moral commitments, or those who are without particular convictions in this regard. What it cannot claim, however, is a universal, normatively binding expertise. Its scope is much more modest, as its practitioners must also be.

B. Epistemological Objections

Epistemically, skepticism about moral expertise focuses on whether, if there is a truth about the right or the good, it is possible for anyone to know it, and especially whether and how some could know it better than others. Even if one accepts the possibility of moral facts, how are we to come to know such facts? Because they are not like scientific facts, it is not possible to design experiments or instruments to capture the truth from the world in the way that, for example, light rays can be recorded on treated surfaces. Even if it is stipulated that some individuals are better than others at identifying moral facts, there is the problem of lay identification of moral experts. That is, if laypeople cannot themselves identify moral facts, what serves as a reliable means of their identifying moral experts vs. imposters? So, even if we stipulated that some CECs were in fact moral experts, it seems impossible that we could identify who was an expert and what training conveyed that kind of expertise. Absent a transparent means of identifying such experts, we would be right to worry about the methods used to identify such experts.

Ethics expertise, on the proposed definition, escapes the epistemological critique, because the subject matter of ethics expertise is accessible to non-experts. The expert opinions can be adjudged by laypeople (at least in principle), and justification can be offered for various recommendations that are subject to debate, clarification, and expansion. The difficulty will be in establishing what counts as the proper subject matter, but once the
subject matter is decided on, it will be public knowledge, and thus subject to debate on individual points. It is important to reiterate that debate on each item will not depend on the assertion of a privileged and mysterious epistemic access to the truth. Critics could fault the subject matter, the training, or the success individual consultants have in mastering the material, but the epistemological access to the material is as straightforward as in many other kinds of professional training.

C. Conceptual Arguments against Moral Expertise
Here I consider three objections which share the feature of objecting to moral expertise because of some conceptual tension inherent in the concept. The first, the “autonomy” objection, objects to moral expertise because it seems to undermine the conditions necessary for an agent to act morally. The second, the “multiple expertise” objection, points out that no expert can possibly function as an expert in all moral systems, which seems required for moral experts in a pluralistic society. Finally, the third objection, the “neutrality” objection, faults moral expertise for pretending to a neutrality it cannot possess. I argue that for the most part, ethics expertise escapes these objections, and to the extent that it is subject to the final objection, it may be the least problematic avenue available to us.

1. The Autonomy Objection
One objection to moral expertise is that reliance on an ethics expert may compromise the autonomy required for moral action. To rely on an ethics expert, the argument goes, would be to act heteronomously. That is, though someone may act in accordance with morality when following the advice of a moral expert, he may not actually be acting morally if morality requires understanding and endorsing for himself the reasons for acting as he does. Reliance on an ethics expert who offers “ethics outsourcing” — the service of giving individuals moral answers — may thus threaten to subvert a necessary condition for moral action.

This version of the autonomy objection is extremely demanding, and poses a model of moral behavior virtually impossible to achieve, so it will not be addressed further. However, there is a less categorical version of the argument: in some sense, it makes no sense to suggest that someone has behaved morally if they have simply done what someone else told them to do. In order to be truly ours, and worthy of blame and praise, actions must engage our executive function, or will, after reflection and consideration. Though it is not necessary that every aspect of a moral decision be radically autonomous, at some point a person must render a decision which is actually his rather than being merely a mimicking of something suggested by another. Does the proferring of ethics expertise prevent this possibility?

Julia Driver considers this point in “Autonomy and the Asymmetry Problem.”25 She notes that some find objectionable the notion of moral expertise but not, for example, the notion of aesthetic expertise, and that the lack of autonomy involved in deferral to a moral expert is usually taken to be the problem. As she articulates a version of the problem, “The worry is that indirect justification just isn’t the right sort of justification to warrant a claim of normative knowledge.”26 That is, if the individual rendering the moral judgment cannot offer much justification himself for the judgment, it seems wrong to claim that it is a “moral judgment” at all. He does not understand what he is claiming, so
he cannot be credited with judgment or knowledge. After all, a child can be trained to respond “2x” when asked for the derivative of $x^2$, but it does not mean she understands such concepts.

Driver’s response to this possibility is that there is nothing inherent in an expert moral assessment that renders it impossible for an individual following the expert’s advice to exercise autonomy. As she puts it, “When an agent decides to accept the testimony the agent is acting autonomously.” This can happen in two ways: either we can come to understand and endorse the reasons the expert gives us, or we can decide not to investigate the matter further for ourselves, instead placing our trust in an expert. When I make a decision to follow the expert’s advice, I commit myself to the consequences of my choice even in the absence of complete understanding. The fact that a clinical ethics consultant offers a recommendation does not prevent a patient, family, or health care professional from autonomously acting on that advice, even if they do not fully understand it. Acting on a recommendation from an ethics expert is therefore compatible with acting autonomously, though the fullness of what autonomous action requires may need further specification.

It is worth acknowledging the implication of this conclusion: it opens the door to the possibility of enlisting help when one must make moral decisions. Although there may be objections to particular experts, to the claims they make, or to the manner in which they deliver advice, the objection is not to the idea of an expert per se. In particular, the ethics expertise I advocate, which does not make claims to binding normative knowledge, has a form which lends itself to this kind of aid if such an expert can supply help in working with an individual’s own moral values.

2. The Multiple Expertise Objection

From within a pluralistic society, the idea that a single person, or even small team of people, can adequately serve as moral experts for all moral perspectives seems ludicrous, whether because of limitations on cognitive power or time, or questions regarding the ability to entertain quite diverse moral systems with equal ability. However, it matters what is meant by “expert.” If moral expertise requires that a CEC actually shares the normative commitments of the stakeholder involved, or that the consultant has recognized power within that person’s belief system, it is true that no single person or limited team could play the role of moral expert for a set of individuals with diverse beliefs. It is helpful here to recall the distinction between being “an” authority and being “in” authority: “an” authority possesses expert knowledge about a particular field, whereas someone “in” authority is empowered to act within a particular sphere. So, for example, an ordained priest may be “in” authority to grant absolution in confession, without knowing an extraordinary amount of Roman Catholic theology. On the other hand, an atheist scholar of the Catholic church may be “an” authority in the sense of knowing about church history or current theological provisions, but she will not be “in” authority to marry a couple within the church.

Under my conception of “ethics expertise,” a clinical ethics consultant is an authority, but not in authority, by virtue of her training as a consultant. What does this mean in response to the objection under consideration? If the premise is that advice can only come from those in authority regarding someone’s belief system, then it is true that no single moral expert can serve all, and the attempt to carve out space for “ethics expertise” is useless.
This is a difficult premise to sustain, however. It is possible that a faithful but uneducated Catholic patient or health care professional could be helped by an atheist consultant who knows, when the patient or professional does not, that Catholics usually desire Last Rites when near death, informs the patient of this fact, and calls for a Catholic priest. There is all manner of factual information about which an ethics expert can helpfully inform someone correctly even when the consultant does not share that person’s faith. It is untenable to suggest that in order to be helpful, an expert must share, rather than merely be able to entertain the premises of, another person’s faith.

The implication of this for consultants’ training is that they must learn about prevalent belief systems of those in the hospital (patients and their families, as well as health care team members) and be trained to recognize the limits of their own knowledge and call for aid from a specialist (e.g., a religious authority within the patient’s belief system) when appropriate. Most problems will be able to be addressed with a moderate amount of knowledge, and the consultant can be the expert in this knowledge relative to others in the medical setting, especially when there are a significant number of belief systems in which to attain that moderate knowledge. Because it is not necessary to be a “moral expert” in the sense of being “in” authority in order to offer help, this objection does not defeat the possibility of ethics expertise.

3. The Neutrality Objection

Finally, one might object to moral expertise on the basis that it seems to offer a moral neutrality that is impossible to achieve. That is, clinical ethics consultants (or, for that matter, bioethics media commentators) almost never say, “this is just my opinion, but...,” and instead, often offer quite categorical moral statements. In such cases, when clinical ethics consultants offer recommendations, the implication is that they have successfully abstracted away from any personal commitments and arrived at unbiased, objective judgments. Since we know that this is impossible, we might fault clinical ethics consultation (among other areas of bioethics) for claiming a wider purview than can be sustained — that is, for making false claims.

Here at last is an objection to which ethics expertise is subject. The clinical ethics expert who suggests that a patient’s refusal of further treatment is ethically acceptable surely rules out perspectives from which refusing further treatment is not acceptable, and in that way is not as “neutral” as is suggested, perceived, or desired. Because not all perspectives are presented, the clinical ethics consultant may shape the options from which someone chooses, thus introducing at the very least a selection bias. The advice of a clinical ethics consultant is not always — or even usually — neutral.

What does this objection mean for the practice of clinical ethics consultation? If taken as damning, requiring the elimination of the practice, this stance assumes that no practice which cannot be conducted neutrally is justified. Since we began with the premise that no one is capable of delivering an unbiased, objective judgment, this means that no practices are justified — a clearly absurd result. We know that people are biased, even if they are not always aware of their own biases. Yet we tolerate this bias in other areas — so why not in clinical ethics consultation?

Moreover, although this criticism has traction for clinical ethics consultation, it is not clear that there is a better alternative to this imperfect practice. Critics of clinical ethics consultation do not suggest alternatives to the aid of consultants when patients or health
care professionals are unsure of what path to take. Of course, those who have normative commitments should be free to act on such commitments. But there are others who are not clear or settled in their own normative commitments, and it does not seem more wrong to offer them the aid of an ethics expert than it does to leave such individuals to muddle through on their own. Ethics experts may offer scant comfort, but that may be more comfort than could otherwise have been hoped for.

An important implication follows: consultants arguably should disclose the general normative commitments from which they offer recommendations — for example, that because they support the permissibility of abortion, they find it permissible to terminate a particular pregnancy for the sake of the mother’s health, or that because they have a particular notion of human dignity, they find it permissible for a patient to refuse nutrition and hydration at the end of life.

D. Normative Arguments against Moral Expertise
Although my definition of ethics expertise survives the metaphysical, epistemological, and conceptual critiques, there is in addition a set of normative critiques of the practice which object to the establishment of a cadre of ethics experts under any definition. The following considerations are not meant to be exhaustive of all possible normative arguments against ethics expertise, but I hope to consider some of the main concerns and possible responses. Some of these objections suggest that clinical ethics consultation ought to be conducted only under certain conditions, so in the concluding section, I summarize what this means for the practice.

1. Objection to the Consequences of a Cadre of Ethics Experts
One normative objection to the establishment of a cadre of ethics experts is that individuals may thereby lose control over their decisions, either by ceding moral decision making to experts or having it wrested from them. Carl Elliott includes both possibilities when he worries that:

As professional expertise has expanded into the domain of the self, producing experts in everything from child rearing to marital happiness, it has contributed to the public perception that problems which used to be the responsibility of the individual now fall under the authority of a professional with the proper training.... Bioethicists...extend the reach of expertise even further into the self, claiming special authority over the conscience.

The central feature of this objection is its emphasis on clinical ethics consultants’ influence, or to put it another way, CECs’ participation in the more general trend of individuals’ ceding important, personal decision making to experts. On one end of the spectrum, the concern is that with the advent of a socially recognized group of “ethics experts,” the public may be under the impression that such experts are better at resolving personal problems than individuals themselves, and begin ceding their own decision making to the “experts.” On the other end of the spectrum, the concern is that such experts will take control of individual decision making.

Consider first the claim that clinical ethics consultants may somehow inculcate the belief
that health care professionals, patients, and their families ought to turn moral decision making in medicine over to the “experts.” It is not clear how to interpret this objection because Elliot is making a broad sociological claim, unsupported by empirical evidence, about “the public perception.” We have no information about whether or not the claim is true, or if true, how serious the problem is. Opponents of ethics expertise may inflate, and defendants deflate, estimates of the likelihood of the phenomenon to suit their purposes. Like many attributions of beliefs to others, in the absence of evidence it is often possible to be gravely wrong in such attributions. In light of the possibility of error in a claim like Elliott’s, we ought to have more information about the extent of a problem before we make plans to address it.

Even if the objection were warranted, given the pervasive culture of expertise Elliot notes, registering a special objection to clinical ethics consultation would require making a case that this type of expertise is more disruptive or harmful than, for example, expert advice on relationships or parenting. These are areas in which individuals tolerate, often seek out, and sometimes arguably need expert advice. It is certainly true that some individuals may wrongly or uncritically cede their judgments to “experts,” but that is always the cost of a robust respect for autonomy in an open society. Eliminating the possibility of usurping autonomy by avoiding offering moral advice is not the best way to cultivate a robust citizenry, nor even the best way to facilitate individuals’ making good decisions. Some may require help in order best to ensure that their decisions comport with their values, and as I argued previously, making use of help does not necessarily thwart the possibility of moral action.

With respect to the opposite extreme, that of ethics experts wresting decision making from individuals, again there is no evidence to suggest this is happening. However, the possibility is discussed in the following section.

2. Abuse of Power Objection
It is possible that the recognition of a group of ethics experts conveys power to those experts, rendering abuse of power a possibility. Prior to assessing the vulnerability of my definition of ethics expertise to this objection, it is important to be clear on whether there is such power, and how it might be abused.

Clinical ethics consultants are in a position to speak with patients, family, and health care staff regarding the ethical dimensions of medical cases. In that process, CECs assess salient issues and often recommend a course of action. Whether or not consultants wear a white coat or other symbols of medical power, by virtue of the fact that they act within the hospital context, with the sanction of the hospital, they are arguably part of a powerful health care mechanism. Moreover, they often have completed extensive training in a discipline (e.g., medicine, philosophy, nursing, public health, law), which creates a knowledge and education asymmetry with many patients and families. Finally, they are ethics consultants, and referred to as such, which might imply an expertise regarding morally right action. While the specific dimensions of the CEC’s influence vary, there is clearly some degree of power in the position.

What constitutes abuse of power? It cannot be that simply to give advice is to abuse power. After all, we do not think doctors abuse power when they make medical recommendations based on their expertise. Similarly, a clinical ethics consultant making an expert recommendation along the lines I described above would not be abusing power
in virtue of making a recommendation. Therefore, the objection cannot merely be against the proffering of advice.

The power of CECs might be abused, however, had they the power to bind others with their recommendations. A commitment to respect for autonomy requires rejection of such coercion, and rejection of any practice which practiced such coercion. However, CECs do not have such power and regularly reject the possibility that they might. The problem cannot be that CECs somehow possess tyrannical power. Instead, the objection must be to the possibility of subtle manipulation: clinical ethics consultants might manipulate others (consciously or unconsciously) in virtue of their positions. For example, what advice ought to be given to a pregnant patient contemplating a therapeutic abortion? A CEC who personally holds abortion to be wrong might advise the patient against it, while a CEC who personally holds abortion permissible might recommend it. Does this ambiguity make possible an abuse of power?

Even on my definition of ethics expertise, clinical ethics consultation is vulnerable to this critique, which is quite similar to the neutrality objection discussed above. It is surely possible that CECs could manipulate the range of options discussed in a clinical ethics case; no guidelines, certification or accreditation standards, or methods of assessment prevent it. But of course, the adoption of such standards would not prevent it, either. Manipulation is often subtle and insidious; as a result, it may be impossible to prevent someone who intends to manipulate others from doing so. But before assuming that the possibility of manipulation renders the practice of clinical ethics consultation impermissible, it is important to consider how serious this possibility is and whether anything could mitigate the possibility enough to render the practice permissible.

Even if it is possible for clinical ethics consultants to manipulate people’s decisions, it shares that problem with many other professions. The possibility of manipulation is omnipresent: we are exposed to manipulation in advertising, in personal relationships, in employment, and in other pervasive ways. Manipulation sometimes occurs in the very way a choice is presented. One may present (“frame”) a particular fact in two distinct, but accurate ways, which lead to very different choice patterns. The field of behavioral economics has been partly founded on considering how framing and anchoring affect decision making. In medicine, physicians could manipulate patients to accept medical recommendations merely by altering how options are presented — for example, as having a 75% likelihood of curing vs. a 25% likelihood of harming. To “nudge” in behavioral economics is to default to using one accurate description rather than another in order to achieve a particular aim. Given that there is no “neutral” way of presenting information like this, any presentation could be said to be manipulative, so the degree of worry about manipulation in clinical ethics consultation does not seem outside the range of the same worry in other areas.

Nevertheless, as discussed in the neutrality objection, the possibility of manipulation suggests that consultants should at least frame their recommendations as resulting from a certain set of premises. In this way, consultants could acknowledge the possibility of manipulation, clearly state their intention to avoid it when possible, and foster self-awareness regarding the opportunities for unconscious manipulation as a way of practicing with integrity. Because the problem does not seem unique to clinical ethics consultation, and because there are ways in which to mitigate the possibility, this is not a fatal objection to clinical ethics consultation.
III. Elaboration of Ethical Expertise and Further Challenges

Most arguments about moral expertise result from an insistence on extremes of interpretation. Thus, in the absence of objective means of confirming experts’ moral judgments, critics lambast the notion of moral expertise, and with it every possible use that might be made of it (e.g., on ethics committees, institutional review boards, policy-making bodies, etc.). I have argued that ethics expertise is a much more modest notion, which neither invokes metaphysical moral facts nor grants privileged access to the moral realm. Instead, it is an area of knowledge relying on the clinical context (i.e., prognosis, evidence, success rates), institutional policy, state and national law, norms of human behavior (e.g., the likelihood that certain kinds of news will have certain effects on patients and families, or that a particular disagreement will likely result from a patient’s or surrogate’s decision, or that a nurse may have lingering feelings of guilt after participating in a withdrawal of care), and implications of moral premises and principles (e.g., that a Jehovah’s Witness may be opposed to receiving blood products, or that a devout Christian may be opposed to abortion under any circumstances). The expertise is neither decisive nor immune from criticism. It is always contextual in several dimensions, but that does not render it radically relative. Ethics expertise is grounded foremost in the respect for an individual’s right to self-determination, but that establishes only that a patient’s decision must be honored, not how best to help him arrive at that decision or whether the health care team should even offer particular treatment options. Given this rather watery definition of ethics expertise, a critic might be justified were they to claim that ethics consultants are seeking sinecure, motivated to do what they do by prurience or a sense of moral superiority rather than by the actual possession of a distinctive ability. Let me then be more concrete: though we may lack the ability to verify whether ethics experts are correct about moral facts more often than laypeople, we should be able to verify four ways in which they render better recommendations than laypeople:

(1) CECs are better able to identify clearly wrong answers than laypeople (for example, that failing to allow a competent individual to make her own decision is illegal, or that there is an empirical difference between a patient in a persistent vegetative state and a brain-dead patient, or that some, but not all, Jehovah’s Witnesses will be opposed to receiving a certain kind of blood product).
(2) They are better able than laypeople to reason from a given moral premise to its implications, based on context, than laypeople.
(3) They are better than laypeople at identifying the full range of moral values and stakeholders involved in a situation.
(4) They may be better than laypeople at creative solutions to clinical dilemmas (viz., Freedman’s “Offering Truth” scenario discussed above) that succeed in achieving multiple ethical goals.

This may appear to be damnation with faint praise, as there is not much in the way of ringing truth on such a conception of ethics expertise. But this comports perfectly with what I have maintained throughout the paper: ethics expertise is a modest but real claim to an expertise which relies neither on deep metaphysical claims about moral facts nor on the ability to make universal, normatively binding recommendations.
IV. Remaining Problems for Ethics Expertise

Even this modest view of ethics expertise is not without problems, however. Set aside the economic question of whether ethics consultation is a net financial gain or loss for institutions. Are there principled problems which render the practice objectionable even if it turns out to be profitable for institutions? I see at least three remaining problems. First, what should we make of the phenomenon of expert disagreement? For example, Fox and Stocking found that ethics consultants presented with seven vignettes concerning end-of-life decisions reached general agreement on only one. Does this undermine the credibility of the ethics expertise of consultants? It is impossible to say. The study does support the claim that the consultants surveyed reached no unanimity (or even consensus) on most of the cases, but the reason for the lack of consensus is not clear. It is possible that there is no real expertise to be had in clinical ethics consultation, or it could be that the means of assessing expertise is wrong, the means for identifying purported experts is flawed (as George Agich points out, is uniformity of conclusion really the best way to measure the legitimacy or success of clinical ethics consultants?), or that there simply has not been time for the appropriate training to reach even a majority of consultants. The bare fact of disagreement in a field in the process of self-development is dispositive of nothing.

A second problem with this account of ethics expertise is what exactly counts as an item of knowledge which all CECs should be expected to know. That is, if ethics expertise is expertise about how arguments run, law and policy, and consensus in the field, then it relies largely on a contested, reigning ethos. Does this enable the smuggling in of robust moral content that leans in a particular ideological direction? Frankly, it may, and this is a serious enough issue that it is worth much more work. However, there are ways to mitigate at least the “smuggling” aspect, and to render the ideological aspect more transparent and amenable to critique. I take the current attempts to credential clinical ethics consultants and set standards for the practice as attempts also to make the practice transparent to others. CECs no more wish to labor in secrecy than others wish for them to do so; thus, by making clear and public what the practice has to offer, and what premises govern the practice, CECs strive to be professional and honest. In terms of content of expertise, there will be, and should be, sustained discussion of the elements of knowledge which ground the practice. I expect that this discussion would take place as a standard curriculum or assessment tool is formulated. It will be very difficult, and the result will not please everyone. But of course, that renders the practice no worse than many, and in its transparency, better than some.

Finally, and related to the previous point, a reliance on a reigning ethos may invite CECs to become hidebound over time, maintaining the status quo. It is difficult to change an entrenched ethos, after all. This is very likely to be the case, as it is with other human endeavors, especially those which are institutional. There is no easy response to this; as with other examples, it will depend on one or more individuals to press the point that an aspect of the practice must change.

V. Conclusion

Opponents of CEC and moral expertise may essentially be objecting to the idea of people
who profess to have the right answer in moral situations, because (1) they hold that there is no such objectively verifiable thing, and (2) this society respects and protects *autonomous* moral decision making more highly than *correct* moral decision making. This forces the CEC into what appears to be a dilemma: either she maintains that she has the right answer, in which case she is exposed to the metaphysical and epistemological arguments, or she holds that she does not have the right answer, in which case she seems a fraud, peddling a fallacious expertise to the gullible masses. The dilemma is false, however: there is something in the middle consisting of an expertise which not all possess but which is modest, helpful, and can be clearly articulated.

I have argued that problems with moral expertise often begin with semantic assumptions. For example, David Archard states, “[a] claim of moral expertise is a claim to command knowledge in respect of the making of normative judgments not commanded by others.”

I have disagreed with the strong version of this definition of moral expertise, and instead have suggested a different definition under the term “ethics expertise.” Of course, the definition I propose is likewise subject to challenge. In its defense, I think the expertise I describe grammatically warrants the term “ethics expertise” inasmuch as it is an expertise in moral matters. If the title of this expertise is objectionable, another may be substituted; not much hinges on the choice of particular terms. However, it is difficult to formulate a suitable replacement which captures the fact that moral issues are addressed in clinical ethics consultation, without asserting that CECs’ recommendations are normatively binding. What I have been concerned to do is describe a kind of expertise that CECs offer, in response to the criticism that their expertise is a sham. I have argued that the expertise involved in clinical ethics consultation is substantive, that it requires the kind of training that other professions undergo, but that it is not normatively binding.

Here I probably break with some practicing CECs who do claim (explicitly or implicitly) to offer normative judgments or who hold that their recommendations are neutral. But in a pluralist society, even if one of the many belief systems possessed by U.S. citizens were objectively true, the right to live out one’s deepest convictions is protected by laws which would forbid the imposition of CECs’ claims to normatively binding judgments. This is, I think, as it should be. Nevertheless, for the many (possibly the majority) whose path in a clinical situation is not clear, there is aid that consultants can offer. For their parts, consultants should be circumspect and modest about the scope of their recommendations, and make clear to others the bases for them.

**Acknowledgement**

Though he likely disagrees with the conclusions I reach, I would like to thank H. Tristram Engelhardt, Jr., for challenging my arguments in a previous draft of this paper. I would also like to thank an anonymous reviewer for the *Journal* for helpful comments.

**References**

1. Of course, several authors have forwarded individual conceptions of expertise, some of which will be discussed in this paper. However, there is no field-wide consensus on a conception of moral expertise which could offer guidance in making decisions about professional standards.

2. Sally Satel, for example, seems to endorse the premises explicitly: “The matter of ethical expertise—what it looks like, who can claim it—is a profound one. Bioethics’ place in the academy, in the clinical

3. Because clinical ethics consultation includes a variety of skills and roles, none of which provide its sole raison d’être, the attempt might be made to avoid the critique altogether by focusing on skills other than moral expertise. For example, it is often observed that clinical ethics consultation regularly involves communication problems. This has been substantiated by at least one empirical study: Forde and Vandvik conclude their study by observing that “[p]roblems related to information/communication may underlie a classical ethical problem. Identification of these ‘hidden’ problems may be important for the analysis, and hence, the solution to the ethical dilemma.” R. Forde and I. H. Vandvik, “Clinical Ethics, Information, and Communication: Review of 31 Cases from a Clinical Ethics Committee,” Journal of Medical Ethics 31, no. 2 (2005): 73-77, at 73. CECs may be most useful to the extent that they can resolve these kinds of problems, which may focus around an ethical question but involve no real ethical dilemma. However, this strategy to avoid the critique is problematic because “ethics” is usually understood to be a main function of the field’s activity. It seems incumbent on clinical ethics consultants to articulate and defend a conception of the expertise they provide in ethical matters which does not fall prey to the objections of absurdity and grave wrongness.

4. Until I make a distinction, in section II, between “moral expertise” and “ethics expertise,” I will use “moral expertise” as the generic term to apply to expertise in moral matters.

5. Of course, many proposals have been made for a conception of moral expertise in clinical ethics consultation. However, pace the Core Competencies documents, which are tentative and advisory, the field has not formally adopted a conception of moral expertise on which to ground certification, accreditation, etc. See American Society for Bioethics and Humanities, Core Competencies for Healthcare Ethics Consultation, 2nd ed., 2011, and American Society for Bioethics and Humanities, Core Competencies for Healthcare Ethics Consultation, Glenview, IL, 1998.

6. And which, incidentally, may be taught, assessed, certified, licensed, and in other ways standardized.

7. In a review of two books on clinical ethics consultation, Laurie Zoloth-Dorfman and Susan Rubin make a similar distinction between “moral expertise” and “ethics expertise”: “[The clinical ethics consultant’s expertise] is an expertise not in morals, but in ethics. In other words, hers is a discipline that functions not by offering declarative normative judgments, but rather by raising critical questions and focusing conversation and deliberation.” L. Zoloth-Dorfman and S. Rubin, “Navigators and Captains: Expertise in Clinical Ethics Consultation,” Theoretical Medicine 18, no. 4 (1997): 421-432, at 430. However, as the focus of the article lies elsewhere, it does not further probe that distinction.

8. “Ethical expertise” is another possible term, but because of the adjective’s ambiguity, it can also mean “expertise delivered in an ethical way.” “Ethics expertise,” on the other hand, refers more explicitly to expertise in ethics.

9. This also includes knowledge of how moral arguments proceed, the objections to which they are vulnerable, the implications of adopting various premises, etc. However, as this is an unobjectionable form of moral expertise, I focus here on the “ethos” content of ethics expertise, and simply include analysis of arguments within the abilities of an ethics expert.

10. For example, that respecting the autonomy of individuals means not treating them contrary to their wishes, or that removing life support from a brain-dead patient is acceptable. I do not mean to imply that
professional consensus means that the correct answer has been discovered or established. However, if patients and family members are uncertain about their choices, it may help to know what other people have thought about an issue. At the same time, consultants must be careful that the provision of such information not be used as a coercive tool.

11. Note that offering even this more robust kind of moral expertise need not violate individual legal rights. The law often protects the rights of individuals to make wrong decisions.

12. A clinical ethics consultant has many duties, only one of which is directly communicating with patients, family, and surrogate decision makers. Other duties include education, policy review or initiation, and consultation with health care professionals, all of which raise the question of the extent of the consultant’s moral expertise. I think the proposed conception of ethics expertise applies to all of these areas, so although I often describe consultants as working with individual patients and family members, it is simply a shorthand description. There is an intriguing wrinkle, however, in cases that do not directly involve patients or even a conversation regarding patients’ wishes. Through “curbside consults,” that is, consultations with health care professionals who simply have questions to ask about a particular case, a consultant can shape the options that later are presented to a patient. Although I cannot fully explore this possibility here, I do consider it below in section II.D.2.

13. One might even argue that the consultant should make such an observation; this possibility is discussed below in Section II.C.3.

14. The use of this term also helps explain why the advice of clinical ethics consultants should not be taken as binding: the recommendation is contextual and will depend on the premises with which one begins.


16. Id.

17. This is similar to Moreno’s description of the talent of “discernment” in clinical ethics consultation, instanced by a consultant’s ability to raise a previously ignored aspect of the case. J. Moreno, “Ethics Consultation as Moral Engagement,” Bioethics 3, no. 1 (1991): 44-56, at 48-49.


20. Of course, individual consultants may in fact make such assertions. On this account of ethics expertise, they would be wrong to do so qua CECs, though of course they may have very robust views as individuals.

21. It is critical to note that no clinical ethics consultant will be able to offer definitive moral advice to all patients. Because knowledge of the metaphysical commitments of each religion or other belief system will vary (as will individual members’ adherence to them), it will be crucial for a consultant to know when he or she has reached the limits of understanding of a patient’s belief system, and when another expert must be requested. For example, an exploration of a Jehovah’s Witness’s convictions regarding the acceptance of blood products may indicate that there are differences of opinion on whether particular components of whole blood may be acceptable. (See Associated Jehovah’s Witnesses for Reform on Blood, “Watchtower Blood Policy Changes,” available at <http://www.awjweb.org/basics/change.shtml> [last visited September 9, 2011] for a discussion on the subtle distinctions and opinions on their acceptability). As a result, the patient may choose to solicit the advice of a religious leader in her own case for guidance that a consultant may not be competent to provide.

22. Too, following scientific convention in naming “moral substances” results, as for “electrons,” “protons,” and “neutrons,” in the unfortunate term “morons.”
23. Michael Cholbi terms this the “credentials problem” and describes it as follows: “Moral experts have no need to seek out others’ moral expertise, but moral non-experts lack sufficient knowledge to determine whether the advice provided by a putative moral expert in response to complex moral situations is correct and hence whether an individual is a bone [sic] fide expert.” M. Cholbi, “Moral Expertise and the Credentials Problem,” Ethical Theory and Moral Practice 10, no. 4 (2007): 323-334.

24. For example, there is the possibility of nepotism and other forms of favoritism if the experts merely identify each other. This may work in religious communities possessing specific structures and methods capable of identifying experts or other leaders (including prayer, divine anointment, etc.), but it seems unlikely at best in a pluralist community.


26. Id., at 623.

27. Id., at 635 (emphasis added).

28. In some religious belief systems, behaving thus may express the moral virtue (or requirement) of obedience.

29. Driver notes that there are still potential problems with using ethics experts’ advice, stemming from the problem of reliability of judgment and whether it can be transmitted impartially or not. These are important points, but they are not concerns about autonomy, which is what is being considered here.

30. I have heard anecdo tally of a hospital chaplain who refused to call a religious authority of the faith requested by a patient, going so far as to attempt to block the door when that authority nevertheless appeared. Regardless of the truth of the story, it offers a cautionary tale: a clinical ethics consultant would be gravely wrong, on her own lights of respect for autonomy, to prevent a patient or family from seeking guidance from an authority they recognize, instead of from a clinical ethics consultant.


32. For example, Smith and Weise entitle their paper, “The Goals of Ethics Consultation: Rejecting the Role of the ‘Ethics Police.’” M. L. Smith and K. L. Weise, “The Goals of Ethics Consultation: Rejecting the Role of ‘Ethics Police,’” American Journal of Bioethics 7, no. 2 (2007): 42-44. The Alden March Bioethics Institute Consultation Services’ policy reads as follows: “Our role is to assist and support, not make decisions for patients.... The options presented by the Consultation Service are of an advisory nature only, and are neither institutionally nor legally binding.” Alden March Bioethics Institute, “AMBI Ethics Consultation Service/General Description,” available at <http://www.amc.edu/Academic/bioethics/ethics_consultation_service.html> (last visited September 9, 2011). For contrast, note that in the Catholic Church, “The Ethical and Religious Directives] are particular law, and hence are binding on any health care agency in the United States that is sponsored by the Catholic Church.” M. T. Hilliard, “Model Policy Concerning the Care to Patients at Life’s End for Catholic Health Care Agencies,” Ethics and Medics 33, no. 8 (2008), available at <http://ncbcenter.org/page.aspx?pid=1024> (last visited September 16, 2011). The United States Conference of Catholic Bishops makes this clear in the Ethical and Religious Directives for Catholic Health Care Services, 4th ed.: “Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.” United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, 4th ed., 2008, available at <http://nccbuscc.org/bishops/directives.shtml> (last visited September 16, 2011). More ambiguously, the first Core Competencies document argues that one of the roles of the ethics facilitation approach to consultation that it advances is to “help to identify a range of morally acceptable options within the context.” See ASBH, 1998, supra note 5, at 6. Similarly, the second edition includes as an appropriate role “help to identify a range of ethically acceptable options within the
context and provide an ethically appropriate rationale for each person." See ASBH, 2011, supra note 5, at 8. Depending on how “ethically acceptable” is characterized (e.g., must one select from among the “ethically acceptable” options?), this may or may not reject the role of an ethics policeman.


36. Fox and Stocking themselves conclude, “This degree of variability in recommendations by ethics consultants may be troubling at first.... But it would be a mistake to construe our results as evidence condemning ethics consultants or the consultation process. The mere presence of variation among ethics consultants does not imply a lack of expertise, nor does it imply that ethics consultation is without value.” Id., at 2581.

37. In addition, the likely form of consultants’ advice is that various options are possible. The appropriate measure of commonality among consultants might be that they (1) identify as inappropriate the same choices and (2) identify similar ranges of possibilities, as well as the kind of additional information that might help them to make a more decisive evaluation. It is also worth noting that the lack of consensus in this study at least fails to support any claims to moral or cultural hegemony among clinical ethics consultants.