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THE NATURE AND VALUE OF BIOETHICS EXPERTISE

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ABSTRACT
In this article, I address the extent to which experts in bioethics can contribute to healthcare delivery by way of aid in clinical decision-making and policy-formation. I argue that experts in bioethics are moral experts, in that their substantive moral views are more likely to be correct than those of non-bioethicists, all else being equal, but that such expertise is of use in a relatively limited class of cases. In so doing, I respond to two recent arguments against the view that bioethicists are moral experts, one by Christopher Cowley and another by David Archard. I further argue that bioethics experts have significant additional contributions to make to healthcare delivery, and highlight a hitherto neglected aspect of that contribution: amelioration of moral misconception among clinicians. I describe in detail several aspects of moral misconception, and show how the bioethicist is in a prime position to resolve that sort of error.

1. INTRODUCTION

Experts in bioethics abound in health-care institutions, serving primarily as ethics consultants and members of institutional ethics committees. Most people familiar with their work seem to accept that there is *some* important role for bioethicists to play in clinical and institutional settings, mainly by aiding in institutional policy development and clinical decision-making, with an eye towards enacting the morally right policy or facilitating a morally acceptable decision. Nevertheless, there is substantial disagreement regarding exactly what experts in bioethics bring to the table, i.e. about what exactly is valuable about their expertise and what their proper role is vis-à-vis policy recommendations and clinical decision-making.

In this article, I aim to describe and clarify what experts in bioethics are specially poised to accomplish in real-world healthcare settings, and to defend the substantial albeit limited clinical value of their expertise. I shall argue that bioethicists' expertise does confer a degree of epistemic authority upon their own substantive moral positions – views about which actions and policies are right and wrong – but that that sort of expertise is properly employed in a fairly limited range of clinical circumstances. I will also argue that bioethicists, in virtue of their particular expertise, can offer a great deal in clinical ethics consultation and policy development that goes beyond merely defending substantive moral views. Acknowledging the wide literature in this area, I shall highlight some particular ways in which bioethicists can contribute to clinical decision-making that have thus far been overlooked – contributions that are related to the correction of moral misconception in the clinic. The upshot will be that the bioethicist's expertise is, for various reasons, substantially valuable to ethically optimal health-care delivery.

2. TYPES OF EXPERTISE

I shall begin by distinguishing two relevant sorts of experts and expertise. A *bioethics expert* or *bioethicist* is someone who has expertise in the academic field of bioethics (or healthcare ethics, medical ethics, etc.). Such expertise can be demonstrated in multiple ways, e.g. through a relevant advanced degree, such as an MA or PhD in philosophy with an emphasis or thesis in bioethics, or a degree in bioethics (or health-care ethics, etc.) itself; through peer-reviewed publications on bioethical topics; through academic positions and successful college-level teaching in bioethics; etc. I shall subsequently have more to say about just what sort of expert knowledge and skill bioethics experts possess.

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A *moral expert*, on the other hand, is one who has special skills, knowledge, or abilities, such that one is, in most cases, significantly better than the ordinary or average person at determining what should be done (i.e. what's right and wrong) morally.[1] A moral expert need not have *highly reliable* judgments about right and wrong actions, i.e. such a person need not get things right in the vast majority of cases; she must only have the ability to judge correctly significantly *more reliably* than the average person. Note: a moral expert need not be a bioethics expert, or even an expert in any area of ethics. In making moral judgments, moral experts might rely on skills, knowledge, or abilities other than those characteristic of an expert in ethics, such as a keen sense of moral intuition.

With the distinction between bioethics expertise and moral expertise in mind, we can distinguish three views about the value of bioethics experts in clinical and institutional settings, vis-à-vis helping patients, clinicians, and policy-makers make the morally right decisions and craft the right policies:

> View 1: Bioethics experts *are* moral experts (on bioethical matters), and can contribute to healthcare delivery (i.e. clinical decision-making and policy-development) in virtue of that expertise. Bioethics experts also have particular skills and knowledge *other* than moral expertise that stand to make significant contributions to healthcare delivery.
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> View 2: Bioethics experts are *not* moral experts (or do not possess a degree of moral expertise that would be useful in practice), but do have particular skills and knowledge that stand to make significant contributions to healthcare delivery.
>
> View 3: Bioethics experts are *not* moral experts and have *no* particular skills or knowledge that stand to make significant contributions to healthcare delivery.

I shall defend View 1. Bioethics experts are moral experts when it comes to bioethical matters, and can contribute to clinical decision-making and policy-formation on that basis, in a narrow range of cases. In addition, in virtue of the skills and knowledge possessed by bioethicists, they are poised to contribute in other ways that stand to significantly help clinicians, patients, and policymakers choose the morally correct course of action or policy in ethically difficult cases.

First, I shall address the issue of moral expertise. Is a bioethics expert indeed a moral expert, and if so, how should such expertise be employed in clinical and institutional settings?

3. THE STANDARD ARGUMENT FOR BIOETHICISTS' MORAL EXPERTISE

As a preliminary matter, note that moral expertise, like all forms of expertise, can be indexed to particular *domains*. For example, due to special experience or knowledge about a particular area, a person might be a moral expert only about issues that fall within that area. I shall suggest that the bioethics expert has both a broader sort of moral expertise, due to her general expertise in practical ethics, as well as particular moral expertise about bioethical issues *per se*, based on the studied application of her expertise in practical ethics to bioethical issues, i.e. moral issues that arise within healthcare and the practice of medicine.[2]

A host of authors have argued that experts in the field of practical ethics (including bioethics) are moral experts in virtue of their expertise in *moral reasoning* and related skills and knowledge.[3] I shall call this the *standard argument* for the moral expertise of the bioethics expert. In this

[1] My distinction between expertise in bioethics and moral expertise is similar to the distinction drawn by Rasmussen (see L.M. Rasmussen. An Ethics Expertise for Clinical Ethics Consultation. *J Law Med Ethics* 2011; 39: 649–661). However, Rasmussen's notion of moral expertise is more robust than is mine, as it includes a definitive ability to arrive at moral truth rather than simply a superior ability to do so when compared with non-experts.

[2] It may also be noted that such an expert might be less reliable than someone who has deep or intimate experience or knowledge about a *particular* sort of situation that falls under the bioethicist's purview; thus, although the bioethicist is a moral expert, and in general (i.e. usually) the most reliable guide to bioethical issues, the bioethicist might not always be the person who is *best* situated to arrive at the morally correct conclusion about a particular case or policy. But that is true of all experts: sometimes special knowledge or experience on the part of a non-expert can render his view more reliable than that of an expert, in a particular case or a certain sub-domain within the expert's area of expertise; in such cases, we might say that the non-expert *is* an expert *in* that sub-domain.

[3] See e.g. P. Singer. Moral Experts. *Analysis* 1972; 32: 115–117; P. Singer. Ethical Experts in a Democracy. In: Rosenthal D, Sehadi F, editors. *Applied Ethics and Ethical Theory*. Salt Lake City: University of Utah Press; 1988. 149–161; B. Szabados. On "Moral Expertise". *Can J Philos.* 1978; 8: 119–120; T. McConnell. Objectivity and Moral Expertise. *Can J Philos* 1984; 14: 193–216; T. Ackerman. The Role of an Ethicist in Health Care. In Anderson GR, Glesnes-Anderson VF, editors. *Health Care Ethics: A Guide for Decision-Makers*. Rockville, MD: Aspen Publishers; 1987. 308–320; D.O. Brink. *Moral Realism and the Foundations of Ethics.* New York: Cambridge University Press; 1989; J.D. Moreno. Ethics Consultation as Moral Engagement. *Bioethics* 1991a; 5: 44–56; J.D. Moreno. Call Me Doctor? Confessions of a Hospital Philosopher. *J Med Humanit* 1991b; 12: 184–196; B. Weinstein. The Possibility of Ethical Expertise. *Theor Med* 1994; 15: 61–75; J. Crosthwaite. Moral Expertise: A Problem in the Professional Ethics of Professional Ethicists. *Bioethics* 1995; 9: 361–379; M. Nussbaum. Moral Expertise? Constitutional Narratives and Philosophical Argument. *Metaphilosophy* 2002; 33: 502–520; R. Sharvy. Who's to Say What's Right or Wrong? People Who Have Ph.D.s in Philosophy, That's Who. *Journal of Libertarian Studies* 2007; 21: 3–24; J. Varelius. Is Ethical Expertise Possible? *Med Health Care and Philos* 2008; 11: 127–132; G.J. Agich. The Issue of Expertise in Clinical Ethics Consultation. *Diametros* 2009; 22: 3–20; B. Gesang. Are Moral Philosophers Moral Experts? *Bioethics* 2010; 24: 153–159; Rasmussen, *op. cit.* note 1.

section I explicate the standard argument; in the following section, I respond to some recent objections to it.

In order to understand why bioethics experts are moral experts, and why the standard argument is compelling, we must understand what sort of expertise bioethics expertise is. We can divide bioethics expertise into two basic categories: *skills* and *knowledge*. The key skill possessed by the bioethics expert is the skill of *moral reasoning.* This, in turn, can be analyzed in terms of (1) *general* critical thinking skills (e.g. skill in constructing and evaluating arguments, recognizing fallacious reasoning, identifying equivocation and needed distinctions, etc.), and (2) *specific* critical thinking skills applied to moral matters (e.g. how to employ morally relevant analogies, adept use of counterexamples, how to distinguish between morally relevant and irrelevant cases and features, etc.). The important kind of knowledge possessed by the bioethics expert is expert grasp of (1) *moral arguments* – the complex reasons for and against various moral propositions – and how such arguments are plausibly employed in novel contexts, and (2) *moral concepts* – the principles, theories, and cases that form the bases of moral arguments, as well as the ideas and distinctions that serve to clarify them.[4] What gives the bioethics expert her special expertise *in bioethics* is (1) an intimate knowledge of arguments about bioethical issues *per se* – including relevant empirical facts and information (e.g. medical, legal, social, cultural, economic, and historical facts) that bear on the issues in question and form, in part, the premises of bioethical arguments – and (2) an expert grasp of the concepts that uniquely feature in those arguments.

Together, skill in moral reasoning plus knowledge of moral arguments and moral concepts (especially bioethical arguments and concepts) allows the bioethics expert to come to conclusions about moral matters (especially on bioethical topics) that are *well-reasoned*, i.e. views that are *supported* by good reasons. Indeed, one cannot form a well-reasoned view on bioethical matters without *some* possession of the sort of skills and knowledge at issue. That is not to say that non-bioethicists necessarily lack such skill and knowledge; but bioethicists possess them to a far greater degree, or are at least far more likely to do so. Furthermore, a *high* degree of such skill and knowledge is required in order to come to *highly* well-reasoned views on bioethical matters. A person who lacks bioethics expertise, therefore, is in all likelihood at a significant disadvantage to the bioethics expert when it comes to reaching conclusions on bioethical issues that are supported by the *best* reasons and arguments. And because positions that are supported by the best reasons and arguments are more likely to be true than those that are not, the bioethics expert is at a significant advantage when it comes to arriving at the truth on such issues.

That is the standard argument for the moral expertise of the bioethics expert;[5] nevertheless, it has its detractors. In the following section I respond to two recent arguments against the notion that bioethics experts are moral experts: a version of what we may call the *argument from disagreement*, and the *argument from common-sense morality*.

4. RECENT OBJECTIONS TO THE STANDARD ARGUMENT AND REPLIES

4.1. The argument from disagreement

It has been suggested that the kind of disagreement about substantive moral issues that exists among experts in practical ethics provides good reason to believe that such experts are not in fact *moral* experts. Now, it should be uncontroversial that expertise in any domain, including practical ethics, must countenance disagreement; thus the mere fact that bioethicists disagree about substantive bioethical propositions is no evidence that they are not moral experts. The argument from disagreement, in any adequately sophisticated form, acknowledges this; the aim of such an argument is to point out one or more relevant differences between the *type* of disagreement present within practical ethics and the type of disagreement that exists in other domains that uncontroversially admit of expertise, such as physics or medicine, and to argue that those differences imply that ethicists lack moral expertise.

The argument from disagreement is not new,[6] but has recently been rehashed by Christopher

[4] There need not be a hard-and-fast distinction between the bioethicist's skills and her knowledge. It stands to reason, for example, that knowledge of various arguments, concepts, and fallacies is *part* of what gives the bioethics expert her skill in moral reasoning.

[5] Some authors add that commitment to unbiased reasoning, along with the accordant ability and willingness to identify potential biases (both in oneself and in others), is another important aspect of expertise in ethics (cf. Crosthwaite, *op. cit.* note 3, Nussbaum, *op. cit.* note 3). Thus, in addition to relevant skills and knowledge, the bioethics expert may possess *values* that increase the odds of arriving at well-supported moral conclusions. This stands to reason, because valuing objective, bias-free thought, as well as the skills and knowledge described above that aid in achieving it, derive from bioethics' firm grounding in philosophy, which more than any other discipline stresses precise, careful reasoning and argumentation, marshalling and evaluation of evidence, and acceptance of a proposition only when there are sufficiently good reasons supporting it.

[6] See e.g. J.R. Bambrough. Plato's Political Analogies. In: Bambrough R, editor. *Plato, Popper, and Politics*. Cambridge, UK: Heffer; 1967. Bambrough claims that ethics experts 'disagree so much and so radically that we hesitate to say that they are experts.' (114) The basic idea here is that if a group of people are indeed experts (in the sense that they are more likely than others to get things right), then their views will coalesce around the right answers, which is not what happens among putative experts in ethics. For compelling objections to this type of argument, see Weinstein, *op. cit.* note 3, McConnell, *op. cit.* note 3, and

Cowley.[7] Cowley claims that the problematic feature that distinguishes moral disagreement among ethics experts from common expert disagreement is that much moral disagreement, even among ethicists, is *intractable*, even in principle. The reason such disagreement is intractable, according to Cowley, is that each party to the disagreement is locked in to a moral perspective that is not rationally transmittable to others – the way one 'sees' the situation grounds one's moral beliefs, and that is something that is neither determined by moral reasoning nor justifiably refuted by it. This is essentially equivalent to the claim that moral debate begins and ends with disagreement over fundamental moral intuitions – moral dispute is, at bottom, a matter of intuitive difference, not a failure of one side to appreciate the best moral arguments or to reason correctly about moral matters. There is thus no role for the ethics expert to play *qua* moral expert – she is not more likely to get things right than those with contrary moral intuitions, because intuition itself, immune to reasoning, forms the essential justificatory basis of moral belief.

There is no doubt that some, perhaps many moral disagreements, are simply clashes of intuition or moral perspective. But in order for Cowley's argument to succeed, it must be the case that *all* moral disagreements, or at least all that arise within healthcare, have this feature. If there are any relevant moral disputes that are amenable to reasoning – any disputes that are not merely clashes of intuition or moral perspective – then Cowley's argument fails: the bioethics expert would then, through her expertise in moral reasoning, be able to arrive at moral judgments about those cases that are more reliably true than the judgments of the non-expert. And Cowley provides no argument (beyond a hasty generalization) for the view that all such moral disagreements are indeed 'bedrock' disagreements. Indeed, it stands to reason that many moral disagreements are based not on intuitive conflict, but on conceptual confusion, poor reasoning, unexamined assumptions, or bias, with regard to at least one party to the dispute, in which case the ethics expert is at a significant advantage. In such cases, disagreement is not necessarily intractable, because the disputants may indeed have intuitive starting-points in common. In general, insofar as we *share* a set of fundamental intuitions, as, plausibly, we often or at least sometimes do, the ethics expert is a moral expert.[8]

That said, if bedrock moral disagreements are the *norm*, then Cowley's argument would at least show that the *scope* of the bioethicist's moral expertise is significantly limited. But there is no good reason to accept that that is the case, and neither does Cowley present an argument for such a premise. Cowley's full-fledged rejection of moral expertise implies that the kind of in-principle intractability at issue is a highly pervasive if not universal feature of moral disagreement, but that conclusion relies on a generalization without reason from the notion that *some* moral disagreements are intractable in the way he describes to the conclusion that most or all are.[9]

Moreover, Cowley fails to realize that the fact that a dispute is based on a clash of fundamental moral intuitions does not entail that moral reasoning cannot resolve that dispute – moral beliefs based on such intuitions are not, as Cowley would have it, immune to reasoning. In such cases, reflective equilibrium may result in a resolution, if, as is often the case, the disputants share *other* relevant fundamental intuitions from which an argument that settles the issue can be constructed. Indeed, a main task of moral reasoning is to resolve conflicts between intuitions, both in the case of a single person having conflicting intuitions and in the case of disagreement. Cowley's vision of moral disagreement involves not only a clash of fundamental intuitions or perspectives, but disputants having implausibly widely divergent and deeply entrenched moral perspectives, such that *no* progress can be made even taking into account the fundamental moral values that they *do* agree about. But insofar as people accept basic and essential moral values and principles like respect for autonomy, fidelity, honesty, beneficence, non-maleficence, etc., progress can be made, at least in principle. Thus, even if Cowley is right that all moral disagreements involve a clash of fundamental intuitions, he would not thereby have shown that moral reasoning is useless or insignificant, and thus would still

D. Archard. Why Moral Philosophers Are Not and Should Not Be Moral Experts. *Bioethics* 2011; 25: 119–127. One important point against this version of the argument from disagreement is that experts in ethics do not disagree more widely or strongly than experts in other domains, and that there is indeed a core body of agreement among ethicists. Moreover, widespread radical disagreement within a certain domain among a group of putative experts does not imply that such people are no better than those outside the group at determining truth within that domain – it only implies that a given expert's view on *those* issues is not *highly likely* to be true. If expertise is taken as being significantly *better* than others at determining truth within a domain (as we are taking moral expertise to be), then widespread radical disagreement is perfectly consistent with expertise, certainly with regard to issues on which experts *do* agree, but also on issues on which experts radically disagree: e.g. non-experts might strongly gravitate towards the *incorrect* view, thus even if there's a 50-50 split among experts, experts are more likely to get things right than non-experts.

[7] C. Cowley. A New Rejection of Moral Expertise. *Med Health Care and Philos* 2005; 8: 273–279; C. Cowley. Expertise, Wisdom and Moral Philosophers: A Response to Gesang. *Bioethics* 2012; 26: 337–342.

[8] Cf. Gesang, *op. cit.* note 3.

[9] Cowley recommends, on the basis of his argument, that the word 'ethicist' be abandoned because those with expertise in bioethics are not 'genuine experts,' and says that 'a moral philosopher has no special role to play on a research or clinical ethics committee.' (Cowley 2012, *op. cit.* note 7, p. 279) In so doing, Cowley naïvely assumes that there are no *other* roles for the expert in bioethics beyond that of moral expert. Those other roles are discussed later in this article.

fail to demonstrate that bioethics experts lack a significant level of moral expertise, based on their expertise in moral reasoning.

4.2. The argument from common-sense morality

A different argument for the view that experts in practical ethics are not moral experts is based on the idea that the basic elements of moral reasoning and moral argument are equally accessible by experts in ethics and non-experts alike. David Archard has recently pushed this line of argument.[10] According to Archard, moral reasoning is based on common-sense morality – those widely-shared judgments and principles that function as moral maxims and form the premises of moral arguments. Even properly 'theoretical' premises, be they fully fledged moral theories or more specific moral principles, are grounded epistemically in common-sense morality. That is, common-sense judgments form the data upon which our theories and principles are based and from which they are derived. According to Archard, because everyone has access to the basic moral maxims that comprise our shared moral intuitions, there is no expertise in the offing –everyone has equal access to moral truth.[11]

I do not wish to dispute the general picture of moral theory- and principle-formation Archard assumes.[12] The main problem with Archard's argument, in my view, is that he fails to distinguish between equal *access* to moral truth and equal *reliability*, i.e. equal *likelihood* of arriving at moral truth. Even if we all have the basic building-block propositions of moral reasoning at our disposal, experts in ethics are especially skilled at moral reasoning itself: at taking those building-block propositions and determining what is *entailed* or *made likely* by them, as well as what is *contradictory* among them and how best to resolve such inconsistency, e.g. how competing considerations ought to be weighed in context, as well as which common-sense views might need to be revised or abandoned. Indeed, Archard acknowledges as much:

> Non-philosophers do not have command of that completed moral theory which represents the systematization, clarification, disambiguation and – where necessary – modification of commonsense morality. A modified or substituted judgment exclusive to moral theory is not one that a nonphilosopher is equipped to endorse or make. They are not so equipped because they have not engaged in the theoretical process of refining and arriving at the final considered judgment.[13]

Based on this insight, Archard (oddly) seems to concede his opponent's point: 'Does that not show that moral philosophers have moral expertise, albeit limited, in being able to make *some* normative judgments that non-philosophers cannot make? Probably. . .'[14] Nevertheless, Archard believes that he has 'showed that moral philosophers cannot, consistent with their own commitments to common-sense morality, claim moral expertise; or that, at most, that expertise is selective and limited.'[15] It is difficult to know what to make of this, given that Archard's explicit aim is to reject the notion that ethicists are moral experts. In the passages quoted here, he seems to be content arguing that the ethicist's moral expertise is 'selective and limited.' But the claim that moral expertise is selective and limited is hardly controversial, even among those who view the ethicist's moral expertise as having broad scope, because selective and limited expertise is consistent with that expertise being applicable in an important or even wide range of cases. The scope of ethicists' moral expertise, for example, might be only *slightly* limited; and even if it is more significantly limited, the cases to which that expertise does apply may be quite important indeed.

It might be suggested, in Archard's defense, that the moral expertise of the ethics expert is *severely* limited, so much so that such expertise would be useless in practice. The problem is that it is entirely unclear why that would be the case. It is true that when common-sense morality is consistent and clear, there is little role for moral reasoning and thus for moral expertise. But it is implausible that that kind of situation is ubiquitous, especially in the context of healthcare. Rather, a significant part of justification in moral belief-formation comes precisely from the reasoning process that refines and prioritizes the tenets of common-sense morality in the name of consistency, and arrives at novel conclusions about which common-sense morality is silent or ambivalent. In difficult cases, especially those in which common-sense morality appears conflicted (many of which arise within healthcare delivery), that sort of reasoning is vital. Thus, it is extremely plausible that the kind of moral reasoning in which bioethicists are experts is indeed important to the ethical delivery of healthcare.

[10] Archard, *op. cit.* note 6. See also C.D. Broad. *Ethics and the History of Philosophy.* London: Routledge; 1952.

[11] Of course, not all such intuitions are shared – but it is implausible that the intuitions of ethics experts are to be preferred, *mutatis mutandis*, over those of non-experts. In any case, that is not the basis of moral expertise advocated by the standard argument; thus I assume that the ethics expert's moral expertise would derive from her superior ability in moral reasoning, not her ability in moral intuiting.

[12] For objections along such lines, see J. Gordon. Moral Philosophers Are Moral Experts! A Reply to David Archard. *Bioethics* (forthcoming).

[13] Archard, *op. cit.* note 6, p. 125.

[14] Ibid: 125. In his conclusion, Archard is more unequivocal: his argument 'shows that [moral philosophers] *are* moral experts only in a limited sense' (italics added), and that they possess 'constrained moral expertise'. (p. 127)

[15] Ibid: 125.

5. THE MORAL EXPERT'S ROLE

Assuming that the standard argument is successful, the question remains exactly how the bioethics expert should utilize her moral expertise in the clinic. The answer to that question plausibly turns on the issue of *how much* of a moral expert the bioethics expert is, i.e. how likely she is to get things right – the more reliable her moral judgments, the more useful they are in practice; and that is something about which the standard argument is silent. More precisely, it turns on how likely the bioethics expert is to get things right when no consensus exists among bioethics experts – if there is such a consensus, then there is no role for any *individual* bioethicist to render judgment, because reliance upon expert consensus is more consistently correct than is reliance upon a single expert's view. And there is indeed general consensus, reflected in law, institutional policy, and the bioethics literature, about many, perhaps most clinical ethical matters, such as the importance of informed consent, criteria for surrogate decision-making and the use of advance directives, confidentiality and many of its exceptions, basic criteria for decisional capacity, the right of competent patients to refuse treatment, the ethical equivalence of withholding and withdrawing care, etc. Of course, there is debate about the details, but the basic elements are widely accepted – there is, as Stephen Wear puts it, a 'canon' of clinical ethics.[16] The fact that bioethics experts are deeply familiar with that canon represents another way in which they are moral experts, as it is a particular instance of the upshot of the standard argument: the canon is, in effect, the culmination of a group-effort at moral reasoning by bioethicists about clinical ethical matters. But when the clinical ethics canon is silent on an issue, or when a particular medical case is too context-specific to be amenable to a simple canonical solution, the moral expert has a role to play. In that case, a bioethicist can offer her view along with the reasons and arguments that support it, and do so as a recommendation – indeed, when it is unclear what the majority of experts would say, the best prospect for arriving at the truth is to solicit the judgment, checked by good reasons and arguments, of someone who is among those most likely to get things right.[17] In that way, an individual bioethicist's view (or the view of a small group of bioethicists) is a proxy for a consensus that *would* exist were the case to be subjected to widespread analysis by bioethics experts; and although it is a *crude* proxy, in that such a view may not be *highly* likely to represent what the consensus would be (even if it is more likely to do so than the view of a non-expert) it is at least *relatively* reliable, and is often the best we can do under the circumstances in question.[18]

Thus, one reason why the bioethicist's role as moral expert is limited in clinical and policy-making settings is that the kind of situation to which that role applies is *rare* – on most issues, the prevailing view of bioethics experts, via the clinical ethics canon, will be relatively clear. Of course, a bioethicist may disagree with certain aspects of the canon; but again, in such cases the views of a *single* bioethics expert are not dispositive, given that the goal is to get things right – when there is an expert consensus (even a relatively weak one, e.g. a 60-40 divide), then the most likely proposition is the one that the majority of experts accepts, all else being equal.[19]

Even in such cases, however, the bioethicist's clinical role as moral expert may be limited further, due to the issue mentioned at the beginning of this section: it may be that the bioethics expert gains only a relatively small advantage over the non-expert when it comes to moral reliability. Perhaps moral reasoning is so difficult that that is the only advantage in the offing. That is, it may be that for human beings, no level of moral reasoning, no matter how adept, can secure a particularly high degree of reliability when it comes to complex ethical issues. In that case, even when expert consensus is elusive (because the canon is silent on an issue or too general or unwieldy to be applicable to a specific situation) we may not be warranted in placing a very high level of confidence in an individual bioethics expert's view (or even, perhaps, the shared view of several such experts), even if we should grant that view some degree of precedence over others. How that would translate into clinical applicability of a given bioethicist's view would vary from case to case, depending on such things as the extent of agreement among relevant parties in a dispute, how uncertain the

[16] S. Wear. Ethical Expertise in the Clinical Setting. In: L. Rasmussen, editor. *Ethics Expertise: History, Contemporary Perspectives, and Application*. Dordecht: Springer; 2005. See also S. Wear. Teaching Bioethics at (or near) the Bedside. *J Med Philos* 2002; 27: 433–445.

[17] For similar arguments see D. Adams & W. Winslade. Consensus, Clinical Decision Making, and Unsettled Cases. *J Clin Ethics* 2011; 22: 310–327. See also D. Adams. The Role of the Clinical Ethics Consultant in 'Unsettled' Cases. *J Clin Ethics* 2011; 22: 328–334.

[18] I do not intend to imply that the bioethicist's recommendation should have political or institutional authority, in that policy or law would dictate that it be followed. Even if the bioethicist's view is the most reliable one, the consequences of imbuing her with such authority may be pernicious. For discussion of this issue, see e.g. Singer, *op. cit.* note 3, Nussbaum, *op. cit.* note 3, and Archard, *op. cit.* note 6.

[19] It is an interesting question just *how* rare cases are about which the clinical ethics canon is silent. Certainly such cases exist; consider, for example, the invocation of probabilistic futility. The question of exactly how unlikely a benefit to the patient must be from a given treatment in order for medical futility to be correctly invoked (such that it is morally permissible to withhold or withdraw that treatment) is one on which there is no standard view. Or, consider decisions about whether to provide life-saving treatment to severely impaired infants, e.g. whether to resuscitate extremely premature newborns on the border of viability, and under what circumstances hospitals may be permitted to override a parent's decision to forgo treatment. Depending upon the child's prognosis, the clinical ethics canon might not be helpful, while sound moral reasoning on an individual basis would be.

parties are about what to do, their receptiveness to moral reasoning, willingness to change their minds, comfort in deferring to others, etc.

6. KEY ROLES FOR THE BIOETHICS EXPERT

If what I have said is correct, then it is unclear just how important the bioethics expert's moral expertise truly is, vis-à-vis contributing to clinical decision-making and policy-development. However, the bioethicist's role as moral expert does not comprise her primary contribution to healthcare delivery. Indeed, many who are skeptical that bioethics experts possess a significant degree of moral expertise nevertheless accept that the expertise of bioethicists gives them a significant role to play in clinical and institutional settings.[20] Various aspects of that role are well-known; nevertheless, I believe that certain ways in which the bioethics expert can help non-experts make morally acceptable decisions have thus far been neglected, and deserve highlighting.

The standard ways in which bioethics experts are thought to contribute to clinical decision-making and policy-formation are through (1) mediation and consensus-building, (2) clarification and explanation of moral issues, concepts, and arguments (this may also include helping relevant parties to use moral reasoning in reaching a conclusion about what to do, as well as *evaluation* of arguments, e.g. pointing out fallacious reasoning; the bioethicist's role as *educator* (e.g. about the clinical ethics canon, the justification of its components, and methods of moral reasoning) also falls under this category), and (3) application of the clinical ethics canon to particular cases that arise in the clinic.[21] These roles are often synergistic. The bioethicist's role as mediator and consensus-builder, for example, derives from her ability to recognize, clarify, and communicate moral reasons and arguments for various positions so that disputants can see things from each other's perspectives, thus facilitating compromise and agreement. In addition, helping clinicians apply the clinical ethics canon is also part of ethics education, facilitates clarification in cases of uncertainty or confusion, and may be part of mediation and consensus-building due not only to the fact that the canon is widely accepted (which puts pressure, both epistemic and pragmatic, on disputants to compromise in line with the canon), but (perhaps more importantly for practical purposes) because it is nearly universally reflected in institutional policy and the law.

I believe it is clear that these roles are helpful vis-à-vis clinical and institutional decision-making and fall within the bioethicist's field of expertise. However, there is a particular role for bioethics experts – one that falls under the categories of clarifier and educator – that deserves special attention, because it addresses an overlooked yet potentially pernicious and plausibly common problem among clinicians: *moral misconception* – in particular, misconception about the clinical ethics canon. And, as I argue below, the bioethicist is specially poised to resolve such misconception.

Resolution of moral misconception may be contrasted with a naïve view of the bioethicist's educational role vis-à-vis the clinical ethics canon: that the bioethicist in the clinic is there to resolve *mere ignorance* of the canon among clinicians, i.e. to aid in cases in which a clinician is simply unfamiliar with the canon and thus unsure about what the prevailing view, policy, or law is as it pertains to a particular issue or issues – simply, the bioethicist provides the relevant knowledge, and education is achieved. Mere ignorance of the canon among clinicians is indeed a problem to be remedied; but misconception about the canon, in its various forms, is a potentially more serious problem because it invites unwarranted decisiveness. Whereas mere ignorance about the canon will often result in hesitance and willingness to seek out information about prevailing ethical, legal, and policy positions, misconception results in acting wrongly because one falsely *believes* one is following the dictates of the canon or acting in a way that the canon permits.[22]

[20] See e.g. J. Avorn. Ethics and Experts; 2. A Physician's Perspective. *Hastings Cetn Rep* 1982; 12: 11–12; T. Beauchamp. Ethics and Experts; 4. What Philosophers Can Offer. *Hastings Cent Rep* 1982; 12: 13–14; A. Caplan. Mechanics on Duty: The Limitations of a Technical Definition of Moral Expertise for Work in Applied Ethics. *Can J Philos* 1982; Supplementary Volume 8: 1–18; L. Zoloth-Dorfman & S.B. Rubin. Navigators and Captains: Expertise in Clinical Ethics Consultation. *Theor Med* 1997; 18: 421–432; Ackerman, *op. cit.* note 3; Gesang, *op. cit.* note 3.

[21] See e.g. Avorn, *op. cit.* note 20; Beauchamp, *op. cit.* note 20; Caplan, *op. cit.* note 20; Ackerman, *op. cit.* note 3; Moreno 1991a, 1991b *op. cit.* note 3; Weinstein, *op. cit.* note 3; Crosthwaite, *op. cit.* note 3; J.C. Fletcher & M. Siegler. What Are the Goals of Ethics Consultation? A Consensus Statement. *J Clin Ethics* 1996; 7: 122–126; Zoloth-Dorfman and Rubin, *op. cit.* note 20; S. Yoder. The Nature of Ethical Expertise. *Hastings Cent Rep* 1998; 28: 11–19; Wear 2002, 2005, *op. cit.* note 16; Gesang, *op. cit.* note 3; A.J. Tarzian. ASBH Core Competencies Update Task Force. Health Care Ethics Consultation: An Update on Core Competencies and Emerging Standards from the American Society for Bioethics and Humanities' Core Competencies Update Task Force. *Am J Bioeth* 2013; 13: 3–13.

[22] It is an open question just what the *extent* of moral misconception is among clinicians, especially compared with mere ignorance of the canon. Empirical research would need to be done in order to adequately answer that question; but it stands to reason that misconception would be a natural *result* of the lacuna left by ignorance of the canon, insofar as clinicians are inclined to 'fill in the gap' in their knowledge of the canon with what *seems* right, or what is morally clear *to them*. Thus, insofar as clinicians lack knowledge of the canon, moral misconception is a real danger (several plausible examples of such misconception are discussed in what follows).

It is important to delineate several distinct types of misconception about the clinical ethics canon to which clinicians may be susceptible. First, a clinician might simply believe that the canonical view is to do *x*, when in fact the canon says to do *y* or is silent on the issue. For example, a clinician may mistakenly believe that the primary criterion for surrogate decision-making is the patient's best interests, and thus direct a surrogate to act on that basis, when in fact the primary criterion is the patient's autonomy (i.e. what the patient would want), which may differ from her best interests. Second, a clinician may mistakenly believe that there is no canonical view on a given subject, and thus rely on her own moral judgment – one that in fact conflicts with the canon. For instance, a clinician may believe that withdrawing treatment is in itself morally worse than withholding treatment, and rely on that view in clinical decisions because she believes that the canon is silent or ambivalent on the matter.[23]

These two types of misconception involve, in part, ignorance of the clinical ethics canon; but they do not represent *mere* ignorance, because the clinician, in these cases, applies her own moral judgment – judgment that is, according to the canon, mistaken. And the remedy for misconception, unlike for mere ignorance, is not simply a matter of *correction*, i.e. explaining the correct canonical positions; it must also involve explaining *why* those views are canonical, because the misconceived, unlike the merely ignorant, are to some degree *attached* to a contrary view, and thus they must be, to that extent, convinced (as opposed to merely told) that they are mistaken.[24] This is something that bioethics experts are especially poised to accomplish. While anyone familiar with the canon can correct mere ignorance (although a bioethics expert will be more intimately familiar with the canon and with relevant details as they apply to particular situations), only a bioethics expert will possess a deep and detailed knowledge of the arguments that support canonical positions, as well as the conceptual and theoretical bases on which they rest. Thus, bioethics experts are by far the most qualified to explain why misconceptions about the canon are in fact *moral* misconceptions, and thus help change the minds of those who accept such views.[25]

A third type of misconception – one that derives from *controversy* within clinical ethics – is also worth discussing. Those who do recognize and accept the clinical ethics canon often do so without questioning it. That is understandable, as constant questioning would undermine a key function of the canon: to provide standard guidelines for practice. But canonical views might be wrong, and many are at least somewhat controversial. Furthermore, the degree to which a policy or practice is canonical varies – certain clinical ethical views may be more or less canonical than others. Thus, clinicians are susceptible to misconception about the degree to which an issue is canonical. Those unfamiliar with the bioethics literature, for example, may not be aware that although physician-assisted suicide is illegal in 46 states and is widely condemned by professional organizations such as the AMA, ANA, and WMA,[26] the rejection of physician-assisted suicide (both ethically and legally) is, even if somewhat canonical, far *less* canonical than most other canonical positions, and due to its highly controversial nature may not even rightly be deemed part of the clinical ethics canon at all.

[23] There are, plausibly, many misconceptions to which clinicians without training in clinical ethics are susceptible, ranging from misconceptions about general moral principles to those about specific practices; for example: that there is a morally relevant difference between artificial nutrition and hydration and other sorts of life-support such as a ventilator, such that patients have a right to refuse the latter but not the former treatment; that death must (in all cases) be harmful to a person; that DNR orders should automatically be suspended during surgery or other procedures that require general anesthesia (as opposed to requiring the patient's or surrogate's reconsideration of the order); that severe cognitive deficiency (e.g. dementia, intellectual disability) entails having a very low or meaningless quality of life; that therapeutic privilege is proper when providing full information about the risks of a needed treatment may convince a patient to refuse that treatment; that the wishes of a deceased person's family should override her documented desire to donate her organs; etc.

[24] That is not to imply that explaining the reasons and arguments that ground canonical views should be omitted when correcting mere ignorance; indeed, that is an important part of any education about the canon. The point is, rather, that providing such arguments is *more* of a necessity when dealing with misconception than with mere ignorance, because one is less likely to correct the error without doing so in the former case than in the latter.

[25] Wear (2002, *op. cit.* note 16) mentions a related role for the bioethics expert: providing sophisticated and cogent rebuttals to clinicians who *reject* the clinical ethics canon, e.g. physicians who cling to a paternalistic view of medical practice. While this does not involve correcting misconception *about the clinical ethics canon*, it does, insofar as the relevant party can be convinced by argument, involve correcting *moral* misconception (at least insofar as the canon itself is morally correct). Notably, Wear is pessimistic about the prospect of convincing such hard-liners, and views the bioethicist's role in these cases as disabusing students and less experienced clinicians who may come under the influence of the misguided clinician.

[26] Council on Ethical and Judicial Affairs, American Medical Association. 2012. *Code of Medical Ethics: Current Opinions with Annotations*. Chicago, IL: American Medical Association; Council on Ethical and Judicial Affairs, American Medical Association. Decisions Near the End of Life. *JAMA* 1992; 267: 2229–2233; World Medical Association. WMA Statement on Physician-Assisted Suicide; WMA Resolution on Euthanasia; 2005. Available at: http://www.wma.net/en/30publications/10policies/e13b/ [Accessed 7 November 2013]; American Nurses Association. Code of Ethics for Nurses with Interpretive Statements. Washington, DC: American Nurses Association; American Nurses Association; 2001; Euthanasia, Assisted Suicide, and Aid in Dying; ANA Position Statements on Ethics and Human Rights. 2013. Available at: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements [Accessed 7 November 2013].

Furthermore, there may be a *range* of canonical views about a given issue, and clinicians familiar with a certain iteration of the canon on an issue may be unaware that there exist equally valid canonical views that differ from it. For example, there is no canonical set of necessary and sufficient conditions for possessing decisional capacity. Law and policy generally settle on a core set of cognitive criteria involving understanding and appreciating relevant information, plus the ability to reason or deliberate rationally on the basis of that information in deciding about one's treatment. But many of those who write in the bioethics literature on decisional capacity and competence argue for additional criteria, such as the ability to *decide* rationally (i.e. in accordance with one's own beliefs about what one ought to do),[27] as well as the possession of a stable and authentic set of *values*.[28] There is, of course, substantial controversy about those additional criteria; but their acceptance is prevalent enough among bioethicists that the sufficiency of the core 'cognitive' criteria is hardly the exclusively canonical position.[29]

Thus there are two types of potential clinical ethical misconceptions about the *lack of controversy* within clinical ethics, involving mistakes about (1) the degree to which a putatively canonical position is controversial, and (2) the variety of canonically acceptable positions (and the attendant controversy among them), especially when some such positions are alternatives to more widely-known or commonly-applied views. Even if an institution or clinician's practice is constrained by policy and law, it is morally instructive and thus important to provide them with any canonically acceptable alternatives, as well as to ensure awareness of which views are only 'weakly' canonical, along with explanation of the arguments that support various positions. A key reason why it is important to make sure that clinicians are aware of such things is to support the progression of ethical policy and practice. In service of that goal, it is vital that clinicians recognize and take account of shifts away from 'official' canonical views, and be able to identify *emerging* canonical positions and trends, e.g. when the more 'official' canon (regarding law, policy, or practice) is silent or ambivalent yet a consensus exists (e.g. within the bioethics literature). More generally: clinicians should be keenly aware that the clinical ethics canon is fluid, as it is dependent upon the arguments that support it; the canon is not dogma. If clinicians are also able to identify which putatively canonical views are plausibly revisable, and the arguments for various alternatives, then clinicians will be able to participate fully in the canon's development, as they should. And it should be uncontroversial that the bioethics expert is in an excellent position, in virtue of her expertise, to correct misconceptions about clinical ethical controversy and to explain relevant arguments, since mastery of such controversy (including knowing what is controversial and to what degree) and deep knowledge of the arguments for various positions are core aspects of her expertise.

7. CONCLUSION

If the arguments presented above are sound, then experts in bioethics have particular skills and knowledge that are extremely useful in clinical decision-making and policy-formation, and can provide significant help to those primarily charged with such duties: clinicians, patients and their families, and administrators of health-care institutions. Bioethicists are both *moral* experts, in that they are more likely than those without expertise in bioethics to arrive at the morally correct course of action or policy, and are able to assume various support roles by way of explanation, clarification, and education about clinical ethics, as well as mediation and consensus-building in cases of ethical uncertainty and conflict, and application of the clinical ethics canon to cases that arise in clinical settings as well as the policies that govern them.[30]

[27] C.M. Culver & B. Gert. Competence. In: Radden J, editor. *The Philosophy of Psychiatry: A Companion*. New York: Oxford University Press; 2004; 258–270; B. Gert, C.M. Culver & K.D. Clouser. *Bioethics: A Return to Fundamentals*. New York: Oxford University Press; 1997.

[28] A.E. Buchanan & D.W. Brock. *Deciding for Others: The Ethics of Surrogate Decision Making*. Cambridge: Cambridge University Press; 1989; R. Dworkin. *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom.* New York: Knopf; 1993; L. Charland. Mental Competence and Value: The Problem of Normativity in the Assessment of Decisional Capacity. *Psychiatr Psychol Law* 2001; 8: 135–45; L. Charland. Decision-Making Capacity and Addiction. In Graham G, Poland J, editors. *Addiction and Responsibility*. London UK: MIT Press; 2011; 139–158; J.O.A. Tan, A. Stewart & T. Hope. Decision-Making as a Broader Concept. *Philos Psychiatr Psychol* 2009; 16: 345–349.

[29] Some issues may lack a clear canonical view not simply because there is no consensus on the issue, but because the issue is so new that a canonical view has yet to develop (this is often the case with the emergence of new biomedical technology). In such cases, the bioethics expert may be able to help *shape* a newly emerging canonical position, especially by helping craft policy, e.g. via institutional committees and government commissions. That said, it is plausible that there exist important differences between the policy-making role of the bioethics expert, as she may be constrained by political and bureaucratic realities, and her role in clinical settings, in which she may be freer to offer a wider array of ethical options and arguments. For discussion of the constraints faced by ethicists in policy-making, see: A.J. Weisbard. The Role of Philosophers in the Public Policy Process: A View from the President's Commission. *Ethics* 1987; 97: 776–785; D. Brock. Truth or Consequences: The Role of Philosophers in Policy-Making. *Ethics* 1987; 97: 786–791.

[30] One might wonder to what extent differing approaches to moral reasoning – e.g. so-called 'principlist' versus 'casuistical' approaches – might affect the way in which bioethicists aid others in moral reasoning, and indeed whether such differences might result in different substantive moral conclusions. Of course, different bioethicists will differ in the way in which they reason morally, due to their particular backgrounds, individual idiosyncrasies, varying strengths and weaknesses in the use of

Importantly, bioethicists are able to ameliorate problems involving *moral misconception* about the clinical ethics canon, in its various forms: misconception about (1) what is canonical, (2) the canon's silence or ambivalence, and (3) controversy within the canon. In light of these roles, the bioethicist's role as moral expert is, by comparison, less important, primarily because her moral expertise is germane only in the relatively rare case in which bioethical consensus is absent, but also because there remains a question of the *scope* of the individual bioethicist's moral expertise, i.e. how *much* of a moral expert an individual bioethicist is (in terms of how likely she is to get things right, and in particular *how much better* she is at doing so than a non-bioethicist). I have not attempted to argue for a particular view of the scope of the bioethicist's moral expertise, but I have suggested that it is *prima facie* unclear what that scope is, and thus caution is warranted when employing such expertise in the clinic. Perhaps that is all that can be said on the matter, or perhaps others can provide reasons for favoring a clearer view of the scope of the bioethicist's moral expertise – in any case, I shall have to leave that topic for another occasion.

moral reasoning, etc., and *any* such differences can result in different approaches to helping others reason morally, and might result in reaching different moral conclusions. And indeed, some bioethicists might focus on the use of moral principles, while others may rely more heavily on case-based reasoning and analogies. But anyone rightly deemed a bioethics expert will make use of the full suite of argumentative strategies and approaches to moral reasoning, and not focus exclusively on one such approach. Furthermore, insofar as reflective equilibrium describes the correct process of moral reasoning, both moral principles and case-based/analogical reasoning are indispensable (a fact that is readily on display in the highest quality work in applied ethics). Moreover, each approach plausibly relies on the other: moral principles gain plausibility because they accord with moral verdicts in particular cases, and casuistical reasoning can only succeed by embracing *some* form of principlism, as it depends upon the notion of *moral relevant features* – a concept grounded in the sort of generality that moral principles express – in order to distinguish good analogies from bad ones. Thus, for genuine bioethics experts, there will be a large degree of convergence on method, even if there are some differences in approach. For an excellent discussion of these issues, see Arras J. Theory and Bioethics. *Stanford Encyclopedia of Philosophy* 2010. Available at: http://www.science.uva.nl/~seop/entries/theory-bioethics [Accessed 5 May 2014].

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