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Scientific Contribution

In defence of ethicists. A commentary on Christopher Cowley's paper

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Christopher Cowley's paper is part of an ongoing, and essential, debate about the role of ethicists in health-care. Ethicists claiming a professional role in health care need to reflect on the nature of that role, and arguments that they have no legitimate claim to moral expertise obviously need to be addressed.

Cowley argues that philosophical training cannot confer ethical expertise, in the sense of the capacity to make and justify normative moral judgements, to which non-experts should defer. His arguments would deny the existence of such expertise whatever the training basis. He argues that moral judgements are essentially personal – located in an embodied personal position/perspective – and so no one has any legitimate claim to special expertise in making, and justifying, such judgements. He concludes that there is no special place for ethicists on committees assessing research, or on clinical ethics committees. He also recommends rejection of the title "ethicist", because of its misleading suggestions of parity with other (genuine) fields of expertise. I want to retain both the term and a role for ethicists in the contexts of clinical care and the assessment of bio-medical research.

Clinical ethicists (and/or ethics committees) are consulted in situations where health professionals feel some moral uncertainty or where there is moral conflict (which induces some uncertainty as to how to proceed). This consultation is often found to be helpful,[1] and this suggests that there is some "expertise" which is being accessed. More significantly, I think that something of benefit could be added to the processes of moral decision-making of a clinician, or any health-professional, were s/he to undertake the training which mostly produces ethicists. If this is so, then there is something which someone so trained (clinician or not) can bring to the clinical context that warrants the description of ethical expertise – though I do not believe expertise requires that one be unchallengable by those who do not share one's training.

There are two main threads in Cowley's rejection of moral expertise, the existence of intractable moral disagreement and the essential location of moral understanding or evaluation within the embodied individual.

Ethics is subject to intractable disagreement; at the end of any process of deliberation and debate, equally well-informed and morally conscientious persons may disagree. We do not all give the same priority to the same values, even where these are shared – and some moral values may not be shared. But I do not accept that this shows there to be no expertise that ethicists can claim. In situations of moral dispute or uncertainty, there may be more than one morally defensible action. The role of the ethicist, or ethics training, is to assist in ensuring that what action is decided on is morally defensible.

Cowley's position is that any normative moral claim must come from (or be accepted into) an individual's own perception of the situation – how it seems, morally, to them. He associates this with a lesser role for reasoning and justification in moral deliberation than ethicists, myself included, have been claiming. He says:

> A great deal of moral experience will be direct and intuitive, without any plausible validating reasons that could be given, or indeed without any reasons that others would expect to be given. In addition, the paradigmatically non-rational emotions make an essential contribution to moral experience.

I accept this as a claim about moral experience, but it cannot work for moral judgements that sustain decisions about how to act relative to professional

roles and responsibilities for other persons. In such contexts "that is how I see it" is not good enough. One must be able to provide grounds supporting decisions, to one's peers and to possible challenges from patients and the community. Someone who does not share one's "perspective", need not be convinced by these grounds that one is right, but they should be convinced that one has engaged in proper moral reflection, and that there is a reasonable moral defence of one's position. The process of discovering and articulating these grounds is what ethicists are trained in, and can assist in.

Metaphors from perception may be unhelpful for characterising situations of moral reflection. They suggest a fixed stance unaffected by the "views" of others, unless one keeps in mind examples such as the perception of aesthetic properties in a work of art. Just as one's perception of a work of art, and perhaps one's resulting evaluation, may be changed by exposure to another knowledgable persons' views, one's "perception" of the morally significant qualities of a situation may be directly modified in discussion with others. Of course, there is a sense in which one's primary values – possibly not consciously articulated – will structure one's response to the moral features one perceives. But these values may also be modifiable – through processes of debate about moral issues and the reflexive testing of intuitions and moral principles (or theories). The weight placed on different good (or bad)-making features in the end rests on the judger, but a trained perception can help in detecting those properties, and in understanding their possible relevance to evaluations. This is the stuff of ethical training (whether from philosophy or more interdisciplinary specialist bioethics training).

Cowley acknowledges that philosophical training may yield some skills and understanding relevant to ethical reflection, such as capacities for coherent justification and argumentation, precise elucidation of concepts, imaginative exploration of implications and assumptions. But the skills of a clinical ethicist must extend beyond mere critical thinking, to include analysis and evaluation specifically of the ethical dimensions of situations.[2] An ethicist should bring to deliberations an awareness of the kinds of factors that are of moral significance and how these relate to moral evaluations – a trained alertness to moral qualities and issues. One might say (at risk of appearing presumptuous) that what ethicists bring is an educated or refined moral perception, as well as skills of reasoning.

Cowley insists that an individual faced with a moral issue must come to their own decision about what should be done. I agree, but it does not mean that there is no role for expert assistance in the deliberation which grounds such decisions, particularly in professional contexts where individuals are answerable to more than their own conscience.

It may be important to note here that I (and many others) think that ethics experts should not assume responsibility for ethical decisions, which rightly belongs to clinicians (or patients).[3] After all, a major ethical issue in clinical contexts has long been the establishing of where legitimate rights of decision-making should rest. Mostly, the role that ethicists see for themselves is that of assisting in moral deliberation.

Finally, a brief defence of the role of ethicists in the assessment of research. Skills of ethical analysis are crucial in assisting the deliberation of any committee charged with the ethical assessment of research. They might be provided by someone with good critical thinking skills and an interest in the area – if that interest leads to wide reading in the literature discussing the ethics of research, and to reflection and debate on the issues raised. This seems to be ethical training (even if taken informally). But I think the presence of someone formally trained in such reflection is important in providing assurance to both the public and research professionals that an ethics committee has conducted a proper ethical assessment (according to the kinds of standards that have been worked out in this area over the past 50 or so years).

Notes

1. A survey of clinicians who consulted the Clinical Ethics Committee of the Auckland District Health Board indicated they found the process very helpful, even where the advice of the committee was not accepted. R. Pinnock and J. Crosthwaite, 'The Auckland Hospital Ethics Committee: The first 7 years'. *New Zealand Medical Journal*, 117(1205), 2004. On line at www.nzma.org.nz/journal/117–1205/1152
2. The American Society for Bioethics and Humanities identifies 'ethical assessment skills' as a fundamental component of the core competencies required for health-care ethics consultation. American Society for Bioethics and Humanities, 'Core Competencies for Health Care Ethics Consultation', Appendix, pp. 165–209, in Mark P. Aulisio, Robert M. Arnold, and Stuart J. Youngner (eds.), *Ethics Consultation: From Theory to Practice*, Baltimore and London: Johns Hopkins University Press, 2003, pp. 178–179.

3. The ASBH report rejects what it calls the "authoritarian" approach to ethics consultation, as making the ethics consultant the primary moral decision maker and displacing 'the appropriate moral decision maker'. American Society for Bioethics and Humanities, 'Core Competencies for Health Care Ethics Consultation', Appendix, pp. 165–209, in: Mark P. Aulisio, Robert M. Arnold, and Stuart J. Youngner (eds.), *Ethics Consultation: From Theory to Practice*, Baltimore and London: Johns Hopkins University Press, 2003, pp. 170–171.