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Debating Ethical Expertise

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Debating Ethical Expertise

ABSTRACT. This paper explores the relevance of the debate about ethical expertise for the practice of clinical ethics. We present definitions, explain three theories of ethical expertise, and identify arguments that have been brought up to either support the concept of ethical expertise or call it into question. Finally, we discuss four theses: the debate is relevant for the practice of clinical ethics in that it (1) improves and specifies clinical ethicists' perception of their expertise; (2) contributes to improving the perception of moral competence of non-ethicists; (3) gives insight into complementary styles of argumentation of ethicists and non-ethicists; and (4) contributes to the awareness of the problem of professional-building of (clinical) ethicists.

In various areas of professional life, ethicists now serve as experts. They serve as members of government commissions, experts on international business panels, and advisors in individual political consultation. Ethicists are chairpersons and members of ethics committees. They facilitate moral deliberations on hospital wards; give advice to individual professionals on how to interpret and manage morally difficult situations; and teach ethics to students, interns, and residents. Ethicists also serve as expert witnesses in court, especially in the United States (Nussbaum 2002). Notwithstanding the significance of the role of ethicists in contemporary public life, the concept of ethical expertise has been, and continues to be, controversial. Some have asked whether expertise is possible at all in relation to moral questions, and, if so, whether it is morally and politically desirable to credit select individuals with an expert status in these questions (Cowley 2005; Varelius 2007).

In this article, we discuss the relevance of the ongoing debate about ethical expertise for the practice of clinical ethics. For our analysis, we primarily refer to the debate about ethical expertise in peer-reviewed journals of medical ethics and clinical ethics. Additionally we refer to

publications by Hubert and Stuart Dreyfus. Dreyfus and Dreyfus aim to identify a specific human concept of expertise, which they distinguish from the type of expertise ascribed to computer expert systems. We find the Dreyfus theory relevant for our discussion because of its inherent concept of experience-based moral competence, which complements analytical theories of expertise in ethical deliberation.

In the following section, we present definitions of expertise and identify some core arguments for and against the concept of ethical expertise in general. Then we explain three theories of expertise in ethics. In the next section, we explore the extent to which the debate is relevant for the practice of clinical ethics. In the final section, we propose a concept of expertise for clinical ethicists.

THE DEBATE ABOUT ETHICAL EXPERTISE

Defining Ethical Expertise

Expertise can be defined as the possession, at a high level, of knowledge and skills in a limited subject area, typically in a professional field. In the Compact Oxford English Dictionary (2008), it is succinctly defined as “great skill or knowledge in a particular field.” The levels of knowledge and skills required for “expertise” can be stipulated in professional codes, teaching and training programs, and job descriptions. Closely related to expertise is the concept of competence. It is a narrower concept, primarily limited to the aspect of skill. Competence has been defined as the quality or extent of being competent (Compact Oxford English Dictionary 2008), which means having the capacity to adequately function or develop in relation to a defined class of skills (Merriam-Webster’s Online Dictionary 2008).

The concept of expertise in clinical ethics restricts the formal definition to content specific to the clinical environment. According to the formal definition of expertise, ethical expertise involves thorough knowledge of moral propositions and ethical theories, and the skills to use this knowledge in a professional way. As to the material constraints, ethical reflection in the clinical setting is primarily problem-oriented. Individual and particular aspects play a significant role, except in the development of institutional guidelines (Gracia 2003). The clinical setting also imposes time constraints on moral deliberation, and in many cases an orientation toward decision making. Deliberation in the clinic must come to an end within a predetermined timeframe, sometimes even before the best possible arguments and conclusions have been found. Readiness to accept the temporality of

conclusions and willingness to reassess them belong to the expertise of the clinical ethicist as well. Finally, discussions and decisions are shaped by interdisciplinary cooperation.

In addition to the formal and material aspects of the definition, we distinguish between a narrow and a broad sense of ethical expertise. The two differentiations are not congruent. In the narrow sense, ethical expertise means theoretical reflection of morality within the material side constraints of the context. In the broad sense, expertise entails substantial knowledge about moral right and wrong, including specific moral conclusions (Singer 1972; Birnbacher 1999; Weinstein 1994). In our discussion, we refer to the term “ethical expertise” primarily in the narrow sense. We thereby include both the formal and material aspects of the definition.

We use the terms ethicist and clinical ethicist to describe a professional function for which training in ethics is required. Clinical ethicists can be either clinicians or nonclinicians. For the purpose of our argument, it is essential that in performing the tasks of an ethicist, be it in ethical case deliberation or ethics consultation, the ethicist’s role and responsibility differ from that of a clinician who is involved in the care of a patient.

Arguments Against Ethical Expertise

Critics have argued that ethical expertise is a flawed idea, both for conceptual and for moral reasons. Conceptually, it has been argued either that moral judgment is not based on facts (Scofield 1993), or that consensus among ethicists has not been, or cannot be, achieved. The general premise of the conceptual critique is that there can only be expertise in a field if an expert’s propositions meet a pre-defined standard of truth, and that this standard needs to be based either on the correspondence between propositions and factual conditions, or on the consensus among practitioners in the field.

In the lack-of-factual-basis argument, the presupposed standard of truth is correspondence between a proposition and a factual condition in the real world. A proposition is determined as true if and only if it corresponds to a condition in reality. Critics of ethical expertise hold that in propositions about morality such correspondence is lacking; that therefore such propositions cannot be true; and that in sum, according to this line of reasoning, there simply is no ethical expertise. For example, Christopher Cowley (2005) argues that moral propositions represent individual personal evaluations rather than factual conditions. Besides, in the debate about the fact-value dichotomy, it has been argued that normative and factual statements are related to reality in different—prescriptive and descriptive—ways.

In the lack-of-consensus-argument, consensus among ethicists is an essential presupposition of moral truth. According to the general premise of this argument, there cannot be expertise unless ethicists can reach consensus. The specific premise is that such a consensus either does not exist, that it has never existed, or, in the strictest version of the argument, that consensus among ethicists cannot exist on principle. Similar to the lack-off-factual-basis argument, the conclusion at least in the case of the strictest form of the argument is that due to the lack of consensus ethical expertise does not exist.

Bruce Weinstein (1994) calls the general premises of both versions of the argument into question. In his view, neither correspondence between moral propositions and facts nor consensus among ethicists can be made a precondition for ethical expertise. Instead, Weinstein suggests that, as long as experts are able to give strong justifications for moral judgments, neither the argument of disagreement nor the argument of lack of a factual basis are sufficiently valid to refuse them expert status. Hence, following Weinstein's argument, ethical expertise is possible regardless of dissent among ethicists about moral judgments, either in fact or in principle. Instead, the coherence of moral arguments with philosophical background theories is considered a sufficient criterion of truth.

Furthermore, it has been argued that in other professional fields with a similar lack of correspondence or consensus, expertise is conceded all the same (Varelius 2007). For example, juridical expertise is hardly doubted even though judicial propositions are not exclusively based on facts either and, except for the factual agreement of written law, consensus among juridical scholars is hardly more prevalent than in ethics. Besides, in technical and scientific expertise, correspondence between facts and propositions can be lacking as well. For example, Karl Popper's (2002) method of falsification demonstrates that the truth of scientific facts and theories can only be tentatively approximated. Philosophers of science have shown that both facts and scientific theories can be subjects of construction. According to Giles Scofield (2008), a specific shortcoming regarding ethical expertise is that bioethicists have insufficiently delivered specific standards of expertise, especially for consultation. Whereas for Scofield himself, this is a sufficient reason to reject ethics consultation altogether, we argue that its potential and limitations should be defined within a discourse about professionalism and the underlying concepts of (clinical) ethics.

In a moral reasoning critique of ethical expertise, some authors have argued that the concept of ethical expertise should be rejected because

of its alleged immoral and disadvantageous implications (Noble 1982; Loughlin 2002; Scofield 1993; 2008). One of the most fervent adherents of such morally inspired critique, British philosopher Michael Loughlin (2002), holds that by fulfilling expectations of the “buyers” of ethical advice, bioethicists undermine critical philosophical reflection upon the status quo and prevent it from being applied in healthcare organizations.

As to the broader social and political implications of the concept, University of South Florida affiliated philosopher Stephen Turner (2001, p. 123) argues that ethical expertise generates two problems for liberal democracies: first, it may introduce inequalities into societies of equal citizens, and second, it poses a problem for state neutrality because opinions of experts and scientists are publicly given an elevated and privileged status above the opinions above non-experts. Such inequalities, especially when granting a special status to ethicists, are considered morally unacceptable (Noble 1982).

A modified version of the moral argument rests on the supposition that ethical expertise contradicts the assumption that everyone’s insight into morality is equally essential and valid. However, it can be argued that this type of contradiction can be avoided and that it is not an essential consequence of the supposition of ethical expertise. For example, Theo van Willigenburg (1999) has pointed out that an ethicist should not give advice without clearly indicating the ethical justifications upon which the advice is based. Transparency and the preparedness to give reasons and to explain the meaning of one’s arguments prevents ethicists from becoming mere neutral observers on the one hand or preachers of moral conclusions on the other.

Theories of Ethical Expertise

Beyond controversial arguments about conceptual and moral flaws of the concept, the debate about ethical expertise has generated some more elaborate suggestions as to its integration into professional contexts. We present three theories of ethical expertise as examples: Weinstein’s (1993; 1994) analytical theory of ethical expertise; the phenomenological account of ethical expertise elaborated by Dreyfus and Dreyfus (1990; 1991; 2004); and reflections about expertise in clinical ethics by David Casarett and colleagues (Casarett, Daskal, and Lantos 1998).

Weinstein first presents a general concept of expertise, without reference to ethics. He differentiates between epistemic and performative expertise. Epistemic expertise refers to someone’s capacity to provide strong justifications for theoretical claims. A justification is strong when it substantiates

a claim with sound reasons. A statement is an expert statement when it is made within a limited domain for which the expert has specialist education and training. Performative expertise is the ability to perform a task well (Weinstein 1994).

In the realm of ethics, Weinstein connects the concept of epistemic expertise to the analytical differentiation between descriptive, normative, and metaethics (Weinstein 1994). Of these three categories, descriptive and metaethical expertise seem to be less controversial. It is easily comprehensible that expertise is required to write a historical study about moral attitudes, or a philosophical interpretation of the meaning of moral concepts. The most relevant and controversial part of Weinstein's theory refers to normative ethical expertise. As normative reasoning is closely associated with substantial moral conclusions and relatively loosely connected to factual conditions, critics doubt the existence of this kind of expertise in ethics.

Against his critics, Weinstein holds that epistemic ethical expertise exists and that it is a sound concept even if and when factual disagreement remains among those who are labeled experts. He argues that neither disagreement about the relevance and interpretation of data nor dissent about ethical background theories alone can undermine the expert status of ethicists. Assuming that the concept of strong justification—as a criterion of normative epistemic expertise—means the degree to which a judgment coheres with an author's philosophical background assumptions, the existence of factual consensus becomes obsolete as a criterion of truth (Weinstein 1994, p. 69).

Coherence between different levels of ethical judgment is considered a necessary and sufficient condition for ethical expertise, not consensus among ethicists about what the true facts, background theories, and conclusions are. The existence of ethical expertise as a sound concept is further supported by concise methodology in argumentation. Finally, ethical expertise depends on the existence of reason in connection with the assumption that moral judgment has an objective status, and that it is not merely subjective opinion.

For Weinstein, performative ethical expertise is defined as the practical ability to live a morally good life. Whereas according to his theory it is considered an integral component of a broader concept of ethical expertise, we argue that the ability to live a morally good life should not be considered an integral part of expertise in clinical ethics. For knowledge and skills to be qualified as a particular professional expertise, there need to be more objective criteria that are independent of the moral integrity of individual subjects. For the moment, a narrow concept of professional

expertise in clinical ethics leaves the questions of practical moral competence open and unanswered.

For a further clarification, we consider the theory of ethical expertise offered by Dreyfus and Dreyfus relevant. This theory presents an approach to what we refer to as moral competence. The authors give a phenomenological account of ethical expertise (Dreyfus and Dreyfus 1991; 2004). Unlike Weinstein, they explicitly do not refer to expertise in ethical deliberation. The core of their theory is the internalized ability of a moral agent to deal intuitively with substantial moral questions, rather than the capacity of a professionally trained expert to give strong justifications for ethical propositions supported by Weinstein. Therefore, we argue that the actual subject of their theory refers to the faculty of substantial moral judgment independent of trained expertise, which we define as moral competence.

At the time of its first publication, the analysis aimed to identify a type of expertise that is characteristically human, in contrast to the computer navigated expertise in electronic expert systems (Dreyfus and Dreyfus 1986). The theory is based upon three presuppositions: (1) a phenomenological account of ethical expertise primarily describes everyday moral coping (as differentiated from ethical deliberation); (2) for the purpose of a clear demarcation of the theory's subject area, one must determine at which point and under which conditions moral coping turns into ethical deliberation and rational choice; and (3) the structure of ethical deliberation should not be read into everyday moral coping (Dreyfus and Dreyfus 1991; 2004).

Dreyfus and Dreyfus identify five stages of expertise acquisition. They argue that this division into five stages is equally valid for the development of any form of practical capability, including moral coping in particular. At the beginning of the learning process, individuals are thought to be fully ignorant of the knowledge and skills, which they are supposed to acquire. In the first stage, the acquisition of moral coping is guided by de-contextualized moral principles. Moral principles summarize and demonstrate basic elements and experience of morality. In the following stages, aspects of real situations in which moral problems occur are added. For the learner of morality, principles increasingly lose their guiding function. Instead, he or she needs to learn how to deal with everyday moral problems in a step-by-step process towards greater complexity. At the highest level of expertise acquisition, abstract principles are abandoned altogether. The morally mature person is thought to be able to grasp directly and intuitively an individual situation, to recognize its morally salient features, and to know what ought to be done (Dreyfus and Dreyfus 1991).

The theory's main methodological presupposition resembles John Dancy's moral particularism in that it assumes that an unprincipled direct view of the singular situation is preferable to a view mediated by theoretical abstractions. According to Dancy, an unprincipled ethical view provides better access to the complexity of concrete moral problems in specific situations than is possible with a view that is biased by ethical principles (Dancy 1993; Harris 2003). However, in contrast to Dancy's theory, which refers to ethical deliberation and moral judgment, Dreyfus and Dreyfus's theory exclusively focuses on moral coping and the intuitive grasping of morally problematic situations. In our view, this feature makes Dreyfus and Dreyfus's concept apt as a theoretical instrument to explore the moral thinking of non-ethicists. It conceives an undisguised view of practical situations and supports the view that moral understanding in professional practice is not filtered by abstract ethical concepts in advance, but rather developed in interaction with professional practice itself.

The third theory, framed by Casarett and coauthors, focuses on the interrelationship between the deliberation and facilitation of ethicists and the moral consideration, judgment, and decision making of non-ethicists (Casarett, Daskal, and Lantos 1998). Casarett and colleagues focus on the authority of the clinical ethics consultant. In general, there are three views on the tasks and responsibilities of clinical ethicists. According to the first view, a clinical ethicist or ethics consultant is expected to provide strong justifications for moral judgments, analogous to a medical specialist who suggests rationales for particular treatments (Jonsen, Siegler, and Winslade 2006). On the second view, the clinical ethicist is primarily a moderator who facilitates deliberations within ethics committees (a stable group with written statutes and agendas) or among a team of healthcare providers when facing a difficult situation on the ward (a transient group, tied together by responsibility for a particular patient in a specific situation) (Finns, Bacchetta, and Miller 1997). The third view aims to combine both advisory and facilitative tasks (Steinkamp and Gordijn 2001). According to Casarett and colleagues, responsibility for moral reasoning and support of non-ethicists in decision making are both part of the clinical ethicist's professional responsibility. In their view, ethicist and non-ethicist need to interact with each other. This view has gained acceptance in clinical ethics nowadays, including within some important umbrella organizations. For example, in its ethics facilitation approach, the American Society of Bioethics and Humanities (ASBH) counts both advising and facilitating as core competencies of ethics consultants (ASBH 1998). The Royal Col-

lege of Physicians (2005) in Great Britain stresses that consultation and facilitation belong to the core activities of clinical ethics. In the light of Casarett and colleague's concept of expertise in clinical ethics, what has been proclaimed by the ASBH as ethics facilitation approach not only is a middle position between ethics consultation on the one hand, and pure facilitation on the other, but should be further elaborated as an integration of ethical expertise and moral competence in a specific organizational form of clinical ethics.

Casarett and colleagues argue not only that advising and facilitating both belong to a clinical ethicist's responsibilities, but also that both of these responsibilities must be considered as genuine forms of ethical expertise (Casarett, Daskal, and Lantos 1998). Referring to Jürgen Habermas's (1990) discourse theory of ethics, the truth of a moral norm can be established by the building, and testing, of acceptance among all moral subjects who are potentially affected by the consequences of general compliance with it. An important goal of this process is consensus. Discourse is a means to reach such consensus. Assuming this theoretical presupposition, ethical case deliberation formally becomes a variety of discourse to test the truth of norms and judgments. Of course this is not the primary function of ethical case deliberation in clinical practice, but formally it can be considered as an aspect that makes the guiding of ethical case deliberation more than just a technique of facilitation. In our view, however, consensus is first and foremost a factual goal of ethical case deliberation, but not a sufficient criterion for the rightness of a moral conclusion. The full meaning of ethical case deliberation itself, finally, can best be understood by consideration of the material constraints that determine its specific shape, together with the formal dimension of expertise.

To summarize the three theories presented here: Weinstein shows that expertise in ethics has both a theoretical (epistemic) and a practical (performative) dimension. Dreyfus and Dreyfus provide a phenomenological interpretation of everyday moral coping. In our view, their concept is an explanation of moral competence of non-ethicists rather than a theory of ethical expertise. Casarett, Daskal, and Lantos develop a theory of ethical expertise specifically for clinical ethics, in which the advisory as well as facilitative responsibilities of an ethicist are identified as parts of ethical expertise. Furthermore, this last theory indicates a way of interaction, in clinical ethics, between ethical expertise (of ethicists) and moral competence (of non-ethicists).

RELEVANCE OF THE DEBATE FOR THE PRACTICE OF CLINICAL ETHICS

In this section, we discuss the extent to which the debate about ethical expertise is relevant for the practice of clinical ethics. We argue that it is relevant in that (1) it facilitates the appreciation of ethical expertise and strengthens clinical ethicists' professional self-perception; (2) it implies an improved appreciation of the moral competence of non-ethicists, which, next to ethical expertise, has been identified as a complementary concept of expertise in the realm of reflection about moral problems; (3) it provides methodical hints for structured cooperation between ethicists and nonethicists by giving insight into the complementarity of their styles of argumentation; and (4) it sharpens awareness of the problem of profession-building among ethicists.

Ethical Expertise of Clinical Ethicists

Expectations concerning ethical expertise are divergent. Some assume that an ethical expert should be able to answer any kind of moral question and solve any moral problem. Others are skeptical because of the supposed conceptual and moral inadequacies associated with ethical expertise and, accordingly, because they believe that an ethicist lacks any ability to solve substantial moral questions. In our view, to clarify such divergent expectations, the notion of ethical expertise needs to be further specified. Turner (2001) has argued that a mere intellectualist idea of ethical expertise may fall short of the complexity of moral problems, especially in professional contexts. An intellectualist notion of expertise means that the concept is reduced to a method of argumentation that employs elements of ethical theory—values, principles, norms, and virtues—to solve moral problems. This notion reflects what we have defined as the narrow concept of ethical expertise, which represents (a selection of) specific capabilities of ethicists.

For the development of an adequate notion of ethical expertise, which lives up to the complexity of moral problems and is differentiated from substantial moral competence, a clarification of the roles and responsibilities of ethicists in professional contexts may be helpful. As to the clinical ethicist, two contrasting roles have been distinguished, namely (1) the ethicist as observer who is responsible for the formal analysis of moral problems and ethical arguments and therefore who keeps a distance and remains detached from the moral problems to be analyzed, and (2) the ethicist as moral problem solver who gets involved and gives substantial advice as to what ought to be done.

Scepticism and critique have been directed predominantly at the idea of the ethicist as problem solver. For example, Alfred Ayer (1954) argues that training in moral philosophy is not a sufficient preparation for the work of an ethicist, or even to improve a person's insight into the moral virtues. Such critique of substantial ethical expertise in the broad sense forms the background for Weinstein's limitation of the idea of epistemic ethical expertise. According to his argumentation, it is only requisite that an expert can give strong justifications for propositions. Expertise does not entail the capability to determine substantially right conclusions.

The arguments in favor of a limitation of the concept of ethical expertise to the analytical and methodological dimension seem to be based on the following three suppositions. First, ethicists lack the competence to answer substantial moral questions within a complex professional context that is not their own. Second, objectivity in ethics is more limited than objectivity in other intellectual disciplines, for example in science, technology, or jurisprudence. Third, the autonomy and independence of nonethicists would be constricted if a broad concept of ethical expertise—including substantial moral conclusions—were maintained.

The narrow concept of ethical expertise has been criticized as well. Cheryl Noble (1982) and Loughlin (2002) argue that of the idea of ethical expertise triggers the idea that difficult moral problems can be "solved" by means of a simple application of methods of ethical argumentation. Indeed, some models of ethical argumentation and application may be considered simplistic. For example, some theories in early bioethics handbooks are designed to solve moral questions by application of principles and norms in a top-down manner (cf. Fox and Swazey 2005; Beauchamp and Childress 1979; 1982; 1989). Later, more complex and subtle methods of relating ethical theory to moral problems indicate a growing insight into the complexity of "applied" moral questions. In addition to the deductive application of principles and norms, bioethicists subsequently have used inductive methods, as well as specification or balancing, and have created approaches of greater complexity (Richardson 1990; 2000; Beauchamp and Childress 1994; 2001; see Jonsen, Siegler, and Winslade 2006).

In current clinical ethics literature, similar advanced views on deliberative methods are being maintained. In different types of situations, one can choose from a variety of methods and protocols of ethical case deliberation (Steinkamp and Gordijn 2003). For example, Clinical Pragmatism is a method modeled after John Dewey's pragmatist philosophy (Fins, Miller, and Bacchetta 1997). A major reason for its development was the insight

that deductive application of principles is an insufficient method for the analysis of morally difficult clinical cases. Ethical norms and principles come into view only after a thorough analysis and interpretation of a situation. Also in other methods, both decision-oriented and reflective (or interpretative), moral norms and principles are relevant points of orientation during the course of ethical argumentation. However, explicitly they are only referred to relatively late in the discussion and only as a second order reference point of deliberation (Steinkamp and Gordijn 2003).

The phenomenon of ethical case deliberation shows how a narrow concept of ethical expertise can be broadened without causing the ethical expert to abandon his or her productive distant and analytical perspective. Relying on methods of ethical argumentation alone is not enough to solve substantial moral questions, even if these methods are adequately complex and sophisticated. Therefore, we argue that it is advantageous to provide structures that guarantee the possibility of complementary interaction between ethical expertise (of ethicists) and moral competence (of (non-ethicist) healthcare providers). We think that a carefully implemented ethics committee in connection with ethical case deliberation on the ward can be developed further into elements of such a structure.

To further illustrate the limitations of a narrow concept of ethical expertise, Madison Powers criticizes Jeremy Bentham, who presumed it is possible to solve moral quandaries by means of a technique of moral argumentation independent of political and juridical circumstances. According to Powers (2005, p. 306),

the emphasis on methods of bioethics and the public reliance on the presumed moral expertise of bioethicists runs the risk of making Bentham's mistake of failing to appreciate that what is at stake under such circumstances are substantive disagreements on the good life for individuals and the proper ends of government within a good social order.

Bentham's mistake, Powers maintains, consists in the fact that he "underestimated the depth of disagreement in his own time, and (that) he falsely assumed that technical refinements in practical ethics can spare one from the inherently political dimension of moral argument" (Powers 2005, p. 320).

Considering Powers's analysis of Bentham, we argue that the narrow concept of ethical expertise, which has turned out to be the more adequate concept to represent the expertise of ethicists, should be related to the concept of moral competence of non-ethicists. Involving moral competence and aligning it to the expertise of the ethicist means that in a structural way,

moral intuitions, judgments, valuations, and interests of moral subjects in healthcare organizations can be taken seriously. The purpose of relating ethical expertise and moral competence to each other is to facilitate the ability of healthcare providers to bring in their professional competence into the reflection and deliberation about moral problems, and structurally to relate the ethicist and his or her expertise to professional practice while maintaining the strength of a distant analytical perspective.

For the practice of clinical ethics, one can conclude that ethical expertise requires an adequate balance of detachment and involvement, and that this balance can be provided when there is both a distinction and cooperation between ethicists (and their ethical expertise) and non-ethicists (and their moral competence). In cooperation, ethicists will focus primarily on the analysis of moral questions (cf. Birnbacher 1999), reasoning, and the process of deliberation, rather than on the determination of what finally ought to be done. Non-ethicists, instead, will receive the support necessary to bring in the best possible knowledge about morally relevant practical details in determining the decisions to be taken.

Moral Competence of Non-Ethicists

According to the definition offered by Peter A. Singer, Edmund Pellegrino, and Marc Siegler (1990; 2001), the main goal of clinical ethics is to improve the quality of patient care by identifying, analyzing, and attempting to resolve the ethical problems that arise in practice. Referring to Dreyfus and Dreyfus, it could be shown that moral competence prior to ethical reflection plays a significant role when moral problems are to be approached. Therefore, appreciation and improvements in the perception not only of professional ethical expertise, but also of moral competence, its role and significance in ethical argumentation, may improve the cooperation between ethicists and non-ethicists, contribute to a better understanding of moral problems in clinical practice, render moral questions more readily answerable, and raise the acceptability of—jointly developed—answers to moral problems encountered in clinical practice.

One way to better understand and appreciate the moral competence of healthcare professionals is to explore their moral views and attitudes through empirical research. For example, Kathleen Oberle and Dorothee Hughes (2001) have revealed that there are differences in the way that doctors and nurses perceive moral problems and in the way they communicate about them. According to Oberle and Hughes, these differences depend, among other things, on the function and on the respective pro-

fessional roles of these healthcare professionals. Empirical studies about morality, however, may deliver more informative results when conceived as continuation of prior conceptual investigation. According to George Agich (1994), before empirical research on moral attitudes can be done, a suitable research question and methodology should be designed in line with conceptual ethical parameters.

Therefore, a second way to investigate moral competence consists of a clarification of its meaning and an investigation of its function in non-ethicists by theoretical reflection. Casarett and colleagues argue that the facilitation of ethical deliberation, in ethics committees as well as team deliberation on the ward, should be considered an integral part of ethical expertise, not only as a technique of consensus formation (Casarett, Daskal and Lantos 1998; Widdershoven 1999). A more elaborate theoretical exploration of moral competence is found in Dreyfus and Dreyfus's account, which we already discussed. The aim of moral competence acquisition according to Dreyfus and Dreyfus is to grasp difficult situations intuitively, without the support of norms and principles.

As a result of Dreyfus and Dreyfus's argument, better insight into moral competence, as well as a careful analysis of this concept, not only amplifies the role of non-ethicists in clinical ethics, it also reveals that ethicists and non-ethicists may employ divergent styles of ethical argumentation and that this divergence and the complementarity of styles of argumentation bring out the strength of both sides. The moral competence of non-ethicist professionals does not involve explicit reflection about ethical notions and arguments, but lies in the competence to deal with the moral particularities of a situation that occurs within a particular professional field. Further research is necessary to explore how interaction between moral perception and normative ethical argumentation can be initiated and improved.

Complementary Styles of Argumentation

We have argued that the interaction and cooperation between ethicists and non-ethicists is necessary given the complexity of moral problems in the clinic and the fact that those moral problems may include substantive disagreements about the good life. Furthermore, we have argued that in such cooperation it would be advantageous if ethicists focus primarily on the analysis of moral questions and moral reasons as well as on the facilitation of deliberation, and not on the determination of what ought to be done. Non-ethicists, instead, should receive the support necessary for them to verbalize morally relevant aspects of situations in practice,

articulate moral quandaries from their professional practice, and take responsibility for the decisions to be made.

To elaborate on the complementarity between ethicist and non-ethicist, we have distinguished between different styles of argumentation. We have exemplified these different styles by presenting Weinstein's analysis of epistemic ethical expertise on the one hand, and Dreyfus and Dreyfus's account of moral competence on the other. According to Weinstein, approaching moral problems requires reference to analytical ethical justifications. Healthcare professionals, patients, and all others who are not ethicists instead will start their moral considerations with a quasi-intuitive perception of particular situations.

Hence, within a complementary and interactive concept of clinical ethics, ethical expertise can focus on the knowledge and ability of ethical deliberation in a narrow sense, in order to utilize its inherent potential of critical distancing and detached reflection. Moral competence, instead, can focus on the internalized faculty of judgment, based on the expertise of healthcare providers in their professional field, and with the profession's internal morality (Brody and Miller 1998). Both ethicists and non-ethicists should be encouraged to employ a style of thinking and argumentation that brings out the strongest traits of everyone's training, experience, expertise, and role-related responsibility.

Particularly in ethical case deliberation, direct interaction between ethicists and non-ethicists is prevalent. Therefore, it is worthwhile to evaluate methods of ethical case deliberation with respect to how participants are encouraged to unfold their respective styles of argumentation. For example, according to established methods, a case deliberation starts with a determination and inventory of the moral problem. This first step is pre-deliberative in so far as it aims to map the moral intuitions and judgments that come to the fore when healthcare professionals ponder about a practical decision. The healthcare professional and his or her moral sense are at the center.

Only after an exploration of the content of this moral sense, does the decision-making process become more deliberative and reflective. According to Weinstein's theory, a part of such deliberation is based on Anglo-American analytical ethics. However, as the example of Nijmegen method and other methods shows, elements of hermeneutic methods can be used alongside the normative elements of ethical theory. What seems crucial is a cooperative practice of the complementary styles of argumentation between ethicist and non-ethicist and that the deliberative process

is organized in a way that the different styles can be practiced to advance the team's deliberation.

Profession Building

Some authors who reject the idea of ethical expertise have criticized the concept of profession building in ethics as well, for basically the same reasons that have been brought forward against the concept of ethical expertise: namely that moral propositions lack a firm empirical basis, that consensus between experts is not available, and that ethical expertise undermines the autonomy of those who receive an ethicist's advice. For example, Giles Scofield (1993) argues that, in order to build a profession, an indisputable concept of expertise should be available for the discipline in question.

Other authors point to the possibility that ethicists, due to the lack of reliable criteria for argumentation and evaluation, may be particularly prone to instrumentalization, for example by employers and clients (see, e.g., Noble 1982; Scofield 1993). Loughlin especially takes a radical position and argues that the mere existence of the discipline of bioethics and of a profession of ethicists creates an illusion that critical reflection takes place. To substantiate his claim, he points to simplistic answers that ethicists supposedly have given to moral questions. Furthermore, he argues that an applied discipline like bioethics will undermine the critical potential of philosophical thinking (Loughlin 2002).

Jan Crosthwaite (1995, p. 365) has pointed out that such fundamental critique may have a positive effect on the quality of ethical expertise. For example, scrutiny from the side of critics may improve critical (self-)awareness of the skill base of ethicists and may foster alertness to the ways in which background theories, assumptions, and interests influence the framing of moral questions (see Animasaun 2006, p. 42). Furthermore, critique leads to the perception of, and discussion about, the necessity of decent criteria of admission to the profession as well their acceptance among its members.

Answering both to the critique and to perceived shortcomings in biomedical ethics, Eric Loewy and Roberta Loewy (2005) resume an older debate and argue that, considering the responsibility of professional ethicists, it is important to build up and establish bioethics as a profession. Their pragmatic arguments are, first, that general binding standards could be developed and used when deciding who should get access to the professional group. Second, once he or she is a member of the profession, monitoring and supervising of the ethicist's functioning and integrity could be demanded. Third, standards of teaching and training, including learning goals and methods, could be agreed upon with greater comparability.

Loewy and Loewy (2005, pp. 76ff.) argue that such a self-regulation should comply with the following conditions: (1) a profession must have a moral—as opposed to merely a technical—end; (2) a profession must serve the public good; (3) members of a profession have to be knowledgeable in a prescribed number of subject areas; (4) a body of theoretical underpinnings and formal mechanism of access into the profession needs to be established; (5) a profession establishes its own criteria of professionalism; (6) mechanisms have to be established to guarantee compliance with criteria of professionalism; and (7) a profession must be self-policing. Referring to the discussion about regulation of healthcare ethics committees (Steinkamp et. al. 2007), self-regulation of ethicists can be a first step toward a broader concept of societal regulation of the profession that is adequate regarding its responsibility. Societal regulation may remain moderate as long as both critical independence of the profession and accepted standards of responsibility and accountability can be warranted.

CONCLUSION

We have analyzed the relevance of the debate about ethical expertise for the practice of clinical ethics considering four points. First, during the debate, specified ideas about the clinical ethicist's role, responsibility, and expertise have come to the fore. For example, those arguments that support a narrow, rather than a broad, concept of expertise seem to be the most adequate. At the same time, moral competence forms an experience-based complement on the side of health care providers. We argue that clinical ethicists' perception of their own expertise can be informed by this debate, with the aim of a further specification of criteria of ethical expertise.

Second, we argue that the debate contributes to a better perception and appreciation of the moral competence of non-ethicists by allocating them a genuine responsibility in clinical ethics, first and foremost as participants of ethical case deliberation on the ward, but also as members of ethics committees. Third, based on Weinstein's and Dreyfus and Dreyfus's theoretical sketches of ethical expertise and moral competence, different styles of argumentation can be identified for ethicists and non-ethicists. Considering their different functions, roles, and responsibilities, it should be advantageous when ethicists and non-ethicists refer to their respective style of argumentation in ethics deliberation in the clinical context. Health care professionals may first and foremost focus on their acquired competence to intuitively grasp the specifics of a morally problematic situation. Referring to a case analysis based on this competence, an ethicist then may employ methods of hermeneutic and normative ethical reasoning as well as

facilitation, in order to guide moral reflection and decision making among health care providers. In this sense, the styles of argumentation of ethicists and non-ethicists are complementary. Finally we argue that profession building and the development of more specific criteria for expertise of ethicists is a still unfulfilled task. The debate about ethical expertise provides some helpful suggestions to continue this discussion. Important tasks will be to develop more specific concepts of key qualifications that should be required from a clinical ethicist, to analyze existing training programs to determine whether they are sufficient to acquire these qualifications, and, if necessary, to enhance these programs and to establish new ones.

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