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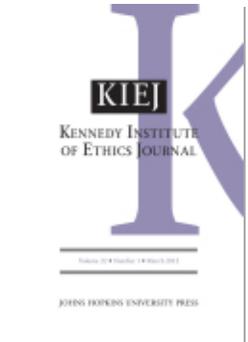
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Ethical Expertise Revisited: Reply to Giles Scofield

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Ethical Expertise Revisited: Reply to Giles Scofield

ABSTRACT. This reply to Giles Scofield's critique of the authors' article in the June 2008 issue of the *Kennedy Institute of Ethics Journal* highlights two main topics. First, contrary to what Scofield suggests, using the terms "ethics" and "morality" interchangeably constitutes an oversimplification that blurs important distinctions. Second, in a representative democracy, ethical expertise and consultation need not generate a "tragic choice" of the kind Scofield has in mind.

In his response to our paper "Debating Ethical Expertise" (Steinkamp, Gordijn, and ten Have 2008) published in the *Kennedy Institute of Ethics Journal*, Giles Scofield (2008a) suggests that the concept of ethical expertise implies leaving moral judgment to professional experts. Leaving moral judgment to an expert, however, would undermine individual citizens' autonomy by prescribing what they should decide, and how. Therefore, he argues that ethical expertise and democracy are incompatible. The alleged incompatibility results in the debate being intractable as it finally constitutes a "tragic choice":

Because there are problems associated with allowing everyone to choose as seems best to them *and* problems with permitting everyone to choose only as seems best to others, we understandably come to see that there are problems associated with our having ethics consultants *and* problems associated with our not having ethics consultants. (Scofield 2008a, p. 379)

Scofield considers our moderate, dialogic model of ethical expertise and moral competence a failed attempt to solve this dilemma. His critique aims at our interpretation of the theory of expertise by Hubert Dreyfus and Stuart Dreyfus (1990); our depiction and use of discourse ethics; and our interactive model of clinical ethics (Steinkamp and Gordijn 2001), which the author finds idealistic. The critique stems from serious concern

about, first, antiegalitarian implications that the author thinks the very idea of ethics consultation might set off and, second, the omission of professional ethics consultants to define binding professional standards (Scofield 2008b).

Several aspects of Scofield's argument deserve closer analysis and discussion. In our reply, we limit ourselves to two of those topics. First, we argue that, contrary to what Scofield suggests, using the terms "ethics" and "morality" interchangeably constitutes an oversimplification that blurs important distinctions. Second, we argue that, in a representative democracy, ethical expertise and consultation need not generate a "tragic choice" of the kind Scofield has in mind.

MORALITY AND ETHICS

An important premise of Scofield's argument is that ethics and morality are synonyms. A pragmatic reason to short-circuit these terms is the author's observation that they often are used that way. "If one equates morality with ethics—and the terms are used interchangeably by the [American Society for Bioethics and Humanities] and others—nonethicists are, at best, two stages below (or beneath) ethicists" (Scofield 2008a, p. 370).

If ethics and morality were synonyms, then any form of specialized access to ethical knowledge, including any derived activity, for example facilitation or counseling by a person trained in ethical reasoning, indeed would imply the consultant's superiority and subordination on the side of consultees. In turn, heightened moral integrity might be expected from those who label themselves—or who are labeled by others—ethical experts. Scofield rightly predicts that ". . . there is no reason to believe that ethical expertise necessarily turns someone into a moral pillar of society." Instead, he is even confident that there is ". . . every reason to suspect, if not believe, that every ethicist's feet are made of clay" (Scofield 2008a, p. 373).

We are not sure whether we would draw the latter conclusion with the same determination. However, the observation that ethical expertise does not make somebody a morally better person confirms our view that ethics and morality should not be used as synonyms. There are essentially two ways to differentiate between these terms in practical philosophy. First, in a 1986 monograph, Wolfgang Kuhlmann opens a debate about (formal) morality versus (substantial) ethical life. Morality and ethical life represent two different dimensions, namely substantial moral values, norms, and

judgments (ethical life, *Sittlichkeit*) on the one hand, and formal as well as universalistic ethical principles and norms (*Moralität*) on the other (Kuhlmann 1986).

The second distinction between morality and ethics is found in our paper on “Debating Ethics Expertise.” According to our terminology, “morality” represents the sum total of substantial moral values, norms, and judgments that are agreed upon within a larger social framework—e.g., a society, a state, a religious community, or an institution—however criticized a specific morality under particular historical circumstances may turn out to be in reality. The term “ethics” instead refers to philosophical reflections about morality, typically elaborated into an argumentative system.

The latter distinction between ethics and morality is common in analytic philosophy. It implies that a professional intellectual approach to common and ordinary human activities is situated at a different level than the activities themselves—i.e., a meta-level. For example, “being an ethical expert” is not the same as “making moral judgments,” which is indeed a common human activity, in the same way that “being a caregiver” is not the same as “taking care of oneself,” which almost every human being is able to do. The difference between the two levels allows for the existence of special expertise, situated at a meta-level with regard to common human activities. This expertise is not contradictory or antagonistic to the more basic level, but it incorporates a systematic reflection upon and generalization of moral experience and judgment about that basic level of common human activities.

MORAL COMPETENCE AND ETHICAL EXPERTISE

Every health care provider, regardless of whether he or she has had any training in ethics, has intuitions and opinions about what is morally right and wrong in relation to professional practice. This is what we mean by moral competence: A competence *sui generis* of health care professionals, not an inferior derivative of (professional) ethical expertise.¹ What a person with academic training in ethics may have that the health care professional may not is a professional command of ethical theories and reasoning. Expertise so understood does not diminish, but rather works to inform and guide a health care provider’s moral competence to develop it to the best of its potential. For example, in the case of facilitation of moral deliberation on the ward according to a carefully elaborated protocol, the contribution of medical professionals is complemented by the involvement of nurses and other professional groups in the deliberation.

Carefully verbalized, this may improve awareness of the moral dimensions of the situation and help to analyze all ethical aspects from more than one dominant perspective.

In our moderate and dialogic approach to expertise, we attribute to the ethicist a narrow concept of argumentative ethical knowledge and skills as well as interactive competence, which is to be used to facilitate and educate health care providers to develop further their competence to substantiate moral judgments. The concept implies a willingness and ability to respect others' moral perceptions and faculty of judgment and to support and provide them with the means to employ their individual moral competence in moral deliberations (Steinkamp, Gordijn, ten Have 2008, p. 188). It does all but imply that health care providers "[surrender their] private judgment . . . to persons with 'ethical expertise'" (Scofield 2008a, p. 373). Apart from that, it is not primarily private judgment that is at stake in health care delivery, but educated moral assessment of professional responsibility.

We consider it essential to face the potential harm that can be caused by the abuse of ethical expertise and to counteract it as much as possible by transparent and clear-cut standards of professionalism. Scofield (2008b) has rightly elaborated on the omission of the ethics consultation community to do so up until now. According to the moderate concept of ethical expertise, ethicists are not to be conceived of as consultants analogous to medical or other specialists. Rather they are architects or mediators who keep spaces open for moral reflection and deliberation about professional practice to take place (Walker 1993). In addition to moral case deliberation on the micro-level of joint decision making within teams, the means to create such space at the meso-level of institutions are Healthcare Ethics Committees (HECs).

Hence, unlike Scofield (2007, p. 45), who claims that ethicists' livelihood and standpoint "depends on and . . . requires a generalized belief in the moral incompetence of others," our concept of ethical expertise requires an identification, appreciation, and fostering of the moral competence of health care professionals in teaching programs, both during professional training (in medical or nursing schools) and in professional practice. The notion of moral competence is intended clearly to appreciate the autonomy of health care providers in making moral judgments, prior to any intervention by an ethicist. Counseling or facilitation notwithstanding, health care providers are and remain the subjects of decision making and problem solving when moral problems occur in clinical practice. As we

have pointed out elsewhere, neither a HEC nor an ethics consultant can or should replace a health care professional's own faculty of judgment (see Steinkamp and Gordijn 2001). Their task is to complement it.

As to moral competence, the contribution of expertise of a person trained in ethics can be rather indirect. For example, an ethicist, as scientific secretary of a HEC, develops draft set of guidelines, which through the process of deliberation become a product of the whole committee. Other examples are the responsibility of ethicists in the development of teaching programs to foster and enhance moral competence and his or her role as moderator in ethical case deliberation. Of course, this is not to say that only ethicists can or should be facilitators of case deliberation, or that nothing other than training in ethics is required to develop a decent teaching program in clinical ethics. What should become evident, however, is that this form of expertise does not require a generalized belief in the moral incompetence of others (Scofield 2007, p. 45).

ETHICAL EXPERTISE AND DEMOCRACY

Democracy is a political system, a form of government, where the people elect representatives for decision making. It is useful to distinguish between different responsibilities. Political decision makers are responsible for government policy; they are not experts or technocrats. During the early stages of the decision making that representatives must undertake on complex issues, they often seek knowledge and advice from professional advisors or (mixed) committees, in order to inform themselves about relevant aspects of the issues. We agree that in democratic societies everyone should be entitled to choose for him-or herself. However, the validity of this statement in the given context of institutional health care delivery is limited in two ways.

The first limitation has to do with representative democracy, where decision making is partly transferred to delegates. It is essential that the procedures of this transfer as well as all of its restrictions be clearly and openly agreed upon. Experts can gather and provide reliable information to aid the representatives with their task. In the end, however, responsibility for making the decisions rests with the representatives (Weber-Hassemer 2008).

A similar distinction can be made in the practice of ethics consultation. Ethicists clarify, analyze, provide information, and suggest options. Clinicians remain responsible for decision making. Ethical experts normally do not, and in fact they never should, make treatment decisions themselves (Steinkamp and Gordijn 2003).

Hence, the claim that expertise in ethical reasoning is incompatible with democratic, nonauthoritarian deliberation is problematic. We argue that deliberation and authority can be reconciled as long as authority, including the authority of an expert, is acquired on the basis of accomplishment and credibility, not coercion. If this condition is met, expertise is not necessarily authoritarian. This implies that an ethical expert need not, and sometimes ought not, limit him- or herself to merely mirroring the judgments of others. Rather, it implies that, for example, the ethicist has a responsibility, if necessary, to point out when propositions are blatantly incorrect and to demonstrate that he or she is sufficiently capable and courageous to dispute others. Nondirectiveness would indeed, as Scofield (2008a, p. 379) rightly points out, come down to being illusionary.

The second limitation has to do with the peculiarities of responsibility in professional organizations. Although we concede that both the doctor-patient relationship and the wider context of health care institutions have undergone and should still be undergoing change as a result of critique of antidemocratic traditions (Lebeer 2002), we think that considerations about democracy are of relative value when it comes to the function of ethical expertise and moral competence in decision making. The reason is that in health care institutions as professional organizations, ethical expertise is not primarily related to the free exchange of opinions between citizens, but to the less arbitrary exchange of experience and judgment among health care professionals, and between health care professionals and their patients. Although these contextual peculiarities render ethical expertise less problematic, they require modesty and wisdom on the side of the ethicist, and safeguards on the institutional (meso-) and societal (macro-)levels both to guarantee the professional standards of ethicists (Loewy and Loewy 2005) and to protect the space needed for moral deliberation.

CONCLUSION

We did not originally conceive our paper “Debating Ethical Expertise” as a contribution to the debate on professional ethics consultation as developed and widely established in U.S.-American health care institutions. Rather, the background of the paper lies in debates within the context of European health systems with their diverse historical and institutional experiences. Our concept of ethical expertise is not a top-down model to reconcile the knowledge of privileged individuals with a presumed hostile environment. Rather it is a bottom-up model to explore the kinds of sup-

port that can be made available to health care professionals, aiming to unfold and enhance moral competence that already is present implicitly in professional practice. Parallel to the contribution of HECs, ethical expertise is seen as an amplification of the tentative developments of democratic structures in a context determined by professional responsibility, rather than a threat to these developments.

Of the numerous points in Scofield's critique that deserve closer attention and study, we have chosen only two to discuss here. We think that to avoid either blending or mutual annihilation of ethical expertise and moral competence, careful differentiation between ethics and morality is required. We also have shown that on our view, democracy and ethical expertise are not mutually exclusive terms.

NOTE

1. In Scofield's view, of the five stages of expertise presented by Dreyfus and Dreyfus—Novice, Advanced Beginner, Competent, Proficient, Expert—the ethical expert represents the highest stage, whereas the morally competent health care provider ranges on a significantly lower level. We might indeed, by our use of the theory of Dreyfus and Dreyfus, by introducing moral competence as a complementary concept to ethical expertise, and by identifying Dreyfus and Dreyfus's notion of ethical expertise with health care providers' moral competence, have invited a reading of this part of our paper different from that which we originally intended. A further elaboration of a theory of moral competence seems to be necessary, in which the independence and autonomy of moral competence is maintained more clearly, and in which reflexivity of morally competent subjects plays a more significant role.

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