

CLINICAL ETHICS: A ROLE THEORETIC LOOK

GEORGE J. AGICH

Medical Humanities and Psychiatry, Southern Illinois University School of Medicine, P.O. Box
19230, Springfield, IL 627949230, U.S.A.

Abstract—The new phenomenon of clinical ethics is analyzed from a role theoretic perspective that differentiates consulting, teaching, watching, and witnessing. Teaching and consulting are seen as main role alternatives in clinical ethics practice, with watching and witnessing defining transitional states that reveal the complexity of clinical ethics. The problem of the legitimation of clinical ethics is discussed in terms of legal, professional, and social accountability and authorization. It is argued that the problem of legitimation is tied up with the related issue of expertise that, in turn, reflects the complex role alternatives of consulting, teaching, watching, and witnessing. Finally, the question of methodology and practice of clinical ethics is explored in connection with the four role alternatives delineated.

Key words—clinical ethics, ethics consultation, expertise,

INTRODUCTION

There are conferences, symposia, journal issues, articles and books devoted to clinical ethics, yet it is relatively unclear what this new phenomenon in medicine amounts to. Should health care providers or medical educators welcome the development of clinical ethics or should they display skepticism or even opposition? Although the alternatives indicated in this question are clear, they hardly provide evidence regarding the nature of the enterprise at issue. For this reason, it would be useful to demarcate the broad outlines of clinical ethics. One approach might be to list features or characteristics that define what self-professed clinical ethicists do. Such a list would include, for example, such diverse activities as consulting, facilitating, teaching counseling, or serving as moral policemen or patient advocates [1, 2]. Without an organizing framework, however, discussing discrete functions tends to promote debate on subsidiary points rather than clarifying main issues.

The goal of the present paper is to give conceptual organization to this field by organizing some of the central possibilities associated with clinical ethics around four social roles [3]. My thesis is that some of the main theoretical and practical problems associated with clinical ethics are expressed in four distinguishable social roles; teaching, watching, witnessing, and consulting. By discussing these activities, we can gain a more secure hold on the phenomenon of clinical ethics and the problems associated with it. This approach is not meant to preclude alternative analyses, but to offer one way to understand some of the questions and issues that are central to clinical ethics. Teaching and consulting are more commonly recognized roles than watching and witnessing, but the latter are especially important because they define transitional states between teaching and consulting. Thus, understanding watching and witnessing affords a way to understand both the affinities and the oppositions between teaching and consulting as aspects of clinical ethics.

TEACHING

Teaching is the best known aspect of clinical ethics [4-6]. Teaching clinical ethics primarily involves teaching ethics in a clinical *setting*. Primarily, clinical ethics teaching is teaching that occurs with health professions students, usually medical students or house staff, on rounds, in wards, or at the bedside—in other words, in situations in which the students are in the midst of their clinical education. Such teaching is a natural culmination of the uniquely applied or practical thrust of bioethics. This teaching has also influenced more traditional classroom teaching of medical ethics. Giving precedence to cases that arise in the actual practice of medicine (or actual cases of health policy) is increasingly evident even in university or college-level bioethics courses and has been stimulated, no doubt, by the increasing availability of collections of cases and case studies that can be used to supplement or replace anthologies or textbooks that previously tended to focus on theories and staple problems such as abortion, allocation of resources, euthanasia, or informed consent. This development is one illustration of the influence that clinical ethics has had on biomedical ethics.

As a social role, however, clinical teaching is an unstable expression of biomedical ethics. Traditionally, students go to the professor who teaches in his own setting. *The* development of programs in medical ethics and medical humanities, however, has brought individuals educated in the liberal arts out of traditional classroom settings and into medical education and the practice of medicine. In some cases, this movement has simply been from the undergraduate or graduate course in medical ethics to the lecture course or seminar for medical students, but it has increasingly involved philosophers and other academics in actual clinical teaching [7-11]. Clinical teaching and learning differ from traditional teaching and learning in a number of ways. First, the setting of the clinic is primarily a practice setting. *The* subject taught is the clinical practice; hence, the clinical teacher understandably has a different orientation than the teacher in more typical academic settings.

One cannot primarily conduct minilectures, review of readings, or discussions of ethical theory. Instead, clinical ethics is taught primarily in response to the daily on-goings of the particular clinical service. This requires the teacher to illumine that setting with specifically ethical reflection and discourse.

This, of course, does not mean that knowledge of ethical theory and concepts is left behind. Knowledge of ethical concepts, principles, and theories certainly serves to organize one's observations and judgments, but the primary goal is not to teach these concepts and principles in some theoretically sophisticated way; rather, the goal is to develop skills of judgment such as identifying the relevant ethical aspects of the case and the ethically acceptable options. Ethical concepts, principles, and theories are certainly discussed in the course of clinical ethics teaching, but such discussion is both motivated and constrained by the case or problem at hand.

Teaching clinical ethics thus has two distinguishable, but related aspects: first, demonstrating by example how to resolve a particular, usually immediate, problematic case and second, contributing to the ethical agency of students by increasing their knowledge and awareness of the ethical and value dimensions of their day-to-day interactions with patients and peers, as well as by fostering the development of specific skills of analysis, decision making, and judgment that characterize mature moral agents occupying the physician's role.

Teaching clinical ethics thus deviates from more typical classroom teaching of ethics or biomedical ethics in at least two important senses. First, clinical ethics is taught in a professional or practice setting. Second, differences in the settings are enhanced by a difference in the conception of the educational process that places greater emphasis on role modeling, character building, and skill acquisition than on theoretical, cognitive understanding. In fact, even within professional medical education there is a difference, and at times a tension, between the orientation of the basic science curriculum and the clinical curriculum, a difference that at least somewhat mirrors differences between college or university medical ethics courses and clinical ethics teaching.

Teachers of clinical ethics undoubtedly bring their primary discipline and disciplinary interests with them. Insofar as they sustain an academic orientation towards medicine they can be described as engaging in a disinterested and objective watching, but such an orientation naturally slides into other orientations that involve less a disinterested observation and more an engaged participation. In order to see the significance of these possibilities, I turn now to the role of watching which seems a natural corollary of the teaching role.

WATCHING

By the term watching I mean an activity engaged in by a number of professionals, mostly academics such as anthropologists, communication specialists, economists, philosophers, or sociologists. It consists in the study, through various formal and informal observational methods and techniques, of the practice of medicine. Commitment to the ideals of objec-

tivity and disinterestedness is a hallmark of watching and is often appealed to as a way to legitimate this activity [12, 13]. Watching consists in a family of activities which range from direct or in-person involvement such as participant observation to highly indirect manipulation of attitude or behavioral survey instruments. In the broadest use of the term, even historians or literary scholars who study medicine through various texts would be seen as watchers.

The features of disinterestedness and objectivity are crucial. Whether the activity actually yields objective, scientifically valid, or statistically adequate results is not important for present purposes, but rather that these activities share a general ideal of learning about medicine by means of a disinterested and disengaged study. For present purposes, however, those examples of watching in which the watcher has direct or in-person involvement in medical practice are most important. The fieldworker in anthropology or sociology provides the clearest examples, but others engaged in clinical ethics also can be described as watchers.

For example, Albert Jonsen has identified himself as a watcher in an article that mainly explains his belief that his own doctor watching is "right and good" [14]. For present purposes, I am more concerned with the language that he uses to describe this activity than his main line of argument to justify his own doctor watching. He says:

In recent years, certain persons have arranged to watch from a distance. The number of the spectators seems to have grown. They are usually academic people, sociologists, anthropologists, economists, or even philosophers. They do not have a license to look and listen to doctors and patients. Their justification is a discipline of some sort that claims its methods and insights will somehow improve the quality of those activities. So they watch at a distance (or sometimes only watch in their mind's eye) and write articles and books, describing, criticizing, counting, clarifying, and occasionally complaining. Our culture had transformed the fascinating pastime of doctor watching into a science. We have elevated the gaping crowd into a bevy of professors and graduate students. We have orchestrated the crowd's obs and obs into a critical

Jonsen goes on to describe his own activities:

I can hardly complain about all this. I am one of those doctor watchers. Decorated only with a doctorate in religious studies, I migrated into a medical school, where I have been professing medical ethics for a decade. I follow the little party of doctors, nurses, and medical students to the bedside of very sick people. I read patients' charts, talk about patients' ills, participate in discussions about patients' fates. Though I eschew the pretension of white coat and beeper, I admit to some gratification at being "inside." More than that, I believe I have some right to be there and that my being there does some good to doctors and patients alike [14, p. 1532].

These passages nicely capture the core elements of watching. Watching is a disinterested, disengaged, and disciplined observation of medicine for the purpose of gaining understanding of the practice of medicine. Of course, it is also possible that watching medicine will benefit medical practice generally, but that is a long-range good to be secured by a general improvement in knowledge and understanding, rather than an immediate benefit. This does not mean

that all benefit is precluded. Rather, the distinction concerns whether the watcher's activities are intended as a contribution to generalizable knowledge of medicine or to the particular observational setting [15].

WITNESSING

A third role with which clinical ethics has affinities is witnessing. In the role of witnessing the distance which the ideal of objective and disinterested observation establishes between watcher and subject is reduced. Watching grades into witnessing whenever the watcher of medical practice is drawn into the scene of social action as agent or resident expert. Anthropologist Charles Bosk, for example, has described, the witnessing role which emerged for him in a study of genetic counselors [16]. The counselors invited him to observe their counseling and decisionmaking activities. He became an invited guest, because they thought he might help them. In effect, the genetic counselors confronted Bosk, the social scientist, with expectations that he was to be immediately useful. He was asked to provide concrete data about such things as how class differences and family structure affected understanding [16, p. 12]. He was also asked to participate in discussion of the handling of cases and in the formulation of policy. In previous work, Bosk studied surgeons [17]. In that work, he reports that he was rarely asked how he would manage cases. Hence, he was able to adhere more closely to the ideal of anthropologist as disinterested observer. In studying genetic counselors, however, Bosk says he found

What separates witnessing for doctors from merely watching them with some well-directed set of academic purposes at hand is this: witnessing seems more directed to establishing or ratifying a moral community than mere watching....

In a curious way I came to symbolize for the group the moral community outside the hospital-my presence in highly problematic situations became a sign of approbation from the larger community. At one level this exacerbated my difficulties giving the group negative feedback, but it resolved them at another. I could speak as "segments" of the community and raise any objections in a voice that did not seem to be my own [16, p. 12].

As described by Bosk, witnessing can be a basic part of the fieldworker's role at three levels. First, at an empirical level, the fieldworker helps to confirm that things are as they seem. He participates in the social definition of reality. As he puts it, "I helped to make the incredible credible" [16, p. 13]. Second, the fieldworker as witness can provide subjects with a sense of legal protection as well. For example, Bosk describes how he was asked to observe cases in which a lawsuit was threatened. In these circumstances, the counselors asked him not to take notes and to forego obtaining consent lest he be called as a legal witness against them in any ensuing lawsuit. Also, when a lawyer was gathering data for a wrongful life case, the group pressed him into service as an 'expert witness' capable of stating what 'really' happened [16, p. 13].

The third, and probably most important, level at which the fieldworker might take on the role of witness is in functioning to establish or to ratify the

moral community that defines the practice in question. Bosk believes that he was invited 'inside' to watch genetic counselors precisely because they expected him to play this religious role of witness. He was allowed to view their uncertainties, anxieties, and doubts, thereby enabling him to see the group of genetic counselors functioning "in an intensely religious and spiritual way" [16, p. 13]. In short, he was invited into the private meditation and ceremonies of a group of genetic counselors wherein they revealed their deepest feelings and beliefs, expressed their uncertainties and anxieties, and carried out their ceremonial rituals. Much like a rabbi at a slaughterhouse, he served to 'purify and sanctify messy situations'. Witnessing is a role that clinical ethicists also often find themselves in [18].

The role of witness brings the person doing clinical ethics into the practice in an intimate fashion; he participates in rather than simply observes the social definition of reality. In effect, the witness is socialized in the practice in question in such a way that he reflects the process of socialization, its definition of reality and its important values and beliefs back to the participants in the practice, thereby validating the sense of reality of the practice, insofar as the witness is not accepted totally within the practice. The witness maintains the quality of stranger to the practitioners.

Simply put, strangers are those individuals who are not socialized or grounded in a group's traditional values and structures [19]. Because they lack such grounding or familiarity, they tend to have more mobility than members of the group. They are unconstrained by the very social roles and activities that define group membership. Hence, they are unfamiliar in the taken-for-granted world of everyday life that constitutes the practice setting. The witness as stranger helps to establish for the group the sense of what it means to be 'inside' and 'outside' the group's process and structure.

Larry Churchill has advocated conceiving the ethicist in professional education as a stranger. As teacher the ethicist in a professional school is a precariously placed stranger. Indeed, according to Churchill, alienation is necessary for the ethicist to be able to advocate and undertake normative inquiry regarding the practice in question. As such, the ethicist in a professional or clinical setting must

seek that critical distance from the profession from which he can gain insights about professional values. The frequent ambiguity and sense of placelessness that accompanies this task is both a professional liability and an asset to the ethicist, as to the stranger [20].

Insofar as the witness maintains this ambiguous role, he is able to function at what Bosk terms 'the empirical level', namely in helping to confirm that things are as they seem. In clinical ethics this often involves confirming the perplexity and tragic consequences that frequently characterize medical decision making and the sense of failure that haunts even the most competent practitioner. In effect, the witness reflects to members of the social group in question the validity or accuracy of their attitudes, experiences, or judgments. This can become problematic if the witness is wrongly infused with a sense of authority that

is seen by members of this group as conferring on practitioners immunity from accountability [21].

In teaching hospitals, for example, the clinical ethicist is usually an academic colleague, teacher and researcher and so naturally is a member of a larger enterprise that weds education and practice. At what point the teacher of ethics moves from being a stranger to an intimate or colleague who is supposed to keep secrets is hard to determine. More importantly, what secrets should be kept just because one is 'inside' the practice? Intractable conflicts are probably infrequent, but their possibility seems to be a natural outcome of the clinical ethicist's role. These conflicts, however, cannot be resolved simply by insisting on an alternative role, namely that of watching [22-24]. The defense that it is 'not my job', because I am a teacher or researcher and not a moral policeman or whatever seems to substitute a task conception of responsibility for moral or role responsibility [25]. There is thus an inevitable and generally overlooked moral tension at the very heart of clinical ethics.

Insofar as witnessing involves ceremonial functions, the clinical ethicists can become the embodiment of group values and ideals; the witness can support and reinforce the status quo, the traditional values of the practice, by offering a quasi-authoritative reflection or articulation of the beliefs and values that define the practice and/or the clinical ethicist can help reshape the practice, especially when there is a continuous relationship with a clerkship or service. It is not surprising that the ceremonial function gives rise to the expectation that the witness will 'protect' practitioners from the threat of outsiders, including lawsuits. The priestly role often carries with it the expectation that the devout will be granted such protection if only they believe according to the true values and ideals of the group. Conformity to group norms requires that ranks be closed around the group; individuals must suppress autonomously derived values, beliefs, or interpretations of reality and instead conform to the authoritative vision that the group defines [26]. The problems that might arise for the clinical ethicist in connection with this functioning are legion.

At the same time, functioning as a witness confers an authority on the clinical ethicist that academic qualifications and effectiveness in watching or teaching does not. It is natural, then, that the clinical ethicist, even if he conceives himself primarily as a disinterested and disengaged academic watcher of medicine, will sometimes take on witnessing functions. This move is fraught with danger, but it also empowers the clinical ethicist in a unique fashion. As witness, the clinical ethicist can try to shape group values and develop new commitments. As witness, the clinical ethicist can actually provide a kind of role model for practitioners. Also, it should not be forgotten that clinicians who invite and make welcome a stranger who primarily watches or teaches are themselves evidencing an openness and trust that invites participating in the transformation of the practice. One natural outgrowth of this participation, whether occasioned through clinical teaching or through witnessing functions, is involvement in consultative activities.

CONSULTING

In the role of consultant the clinical ethicist is engaged in medicine in a unique way as an expert able to offer practically useful advice. The primary expectations involve advice giving or decision making. Unlike the disinterested and objective ideal of the watcher or the integrated, religious, or ceremonial function of the witness, the consultant is expected to address particular problematic cases or issues and to render expert advice, opinion, and recommendations. Unlike the teacher whose role is defined in terms of academic or educational functions, the consultant is primarily a practitioner.

A prerequisite for ethics consultation is the belief that the consultant has special qualifications in the sense of possessing the appropriate expertise and skills. In the typical situation an ethics consultant is requested to bring expertise to bear on a troublesome case or problem. Usually, the consultation is initiated by the attending physician or, in a teaching hospital, by the resident or house staff physician in charge of the case. Occasionally, consultations might be initiated by other members of a health care team or, under the aegis of an ethics committee, by family or patients. These latter possibilities cause ethics consultations to deviate structurally from more typical clinical consultations. To assess these deviations, it is useful to have a clear conception of the main characteristics of typical clinical consultations [27].

First, the clinical consultant is expected to function as an independent professional within the clinical setting, but under the direction of the primary physician. The qualification 'under the direction of the primary physician' is not meant to compromise the independent status of the consultant, but to note that consultations generally do not establish an independent relationship over and against the primary physician patient relationship. Similarly, ethics consultation is directed to problems within or associated with the primary physician patient relationship [28, 29].

Second, the consultant brings to bear relevant expertise, skill, and training in the analysis, identification, and evaluation of problems or issues involved in caring for an individual patient.

Third, the consultant, subject to institutional rules and peer-established procedures, provides a consultative report and/or recommendation primarily to the attending physician, but perhaps also to the patient, family, and other staff involved in the case.

Fourth, the consultative report consists in a review of the case history, discussion of the consultant's findings including the tests performed, statement of the management problem(s), and recommendations for further investigations or interventions to address the problems identified.

There is considerable variation in the details of clinical consultative practice, but the features identified above will usually be exhibited across the board, including ethics consultation. As in clinical consultations, ethics consultation is partly determined by the requesting physician who usually is free to identify the problem or the issues that require attention and thereby to preliminarily define the consultant's involvement with the case. The choice of

an ethics consultant, like that of other clinical consultants, itself affects the consultation process. Consultations requested through a hospital ethics committee, initiated by the request of patients, family members, or other staff, necessarily represent departures from more typical clinical consultations. Also, administrative or staff rules might define the scope of activity of the ethics consultant. Such rules might apply either to all consultations or be specific to ethics consultation. Such rules might specify, for example, whether the attending physician alone or others such as patient, family or nursing staff, can initiate a consultation, whether the consultant should enter notes in the patient's medical record and, if so, where such notation is made—in the progress notes, nursing notes, or elsewhere. The delineation of these (possibly extensive) variations in the process of ethics consultation is an important empirical task that has yet to be carried out [30-34].

Consultation-like activities often occur in the course of clinical ethics teaching. Problematic cases arise in the course of conducting or participating in teaching rounds on a regular basis. Indeed, there seems to be a congruence between cases that seem to require consultation and cases that provide interesting teaching material. This congruence can be problematic if cases are chosen simply because they cohere with well-recognized paradigmatic problems of medical ethics. Exclusive attention to these paradigms can deflect attention from more typical cases or more mundane aspects of practice that may be more appropriate subject matter for clinical teaching and reflection. In any event, advice and help with cases is frequently sought [35]. A sure way for a clinical ethicist to lose credibility with clinical colleagues is to prescind from offering such help. Nonetheless, consulting is structurally and functionally different from teaching.

Ethics consultation assumes a relevant expertise, possession of relevant skills or methods, by which the consultative goal can be accomplished. As an activity it is directed toward the goal of advice-giving or decision making. Unlike the watcher of medical practice, whose goal is primarily to attain an 'objective' knowledge or understanding of medicine for academic purposes and who functions by maintaining a disengaged or impartial observational stance, the ethics consultant is engaged as a specialized practitioner in the clinical setting. Yet, the ethics consultant is not a practitioner of medicine as such, but an individual who brings an independent expertise to bear on problematic cases or issues in medical practice [36]. Compared with medical practitioners, the ethics consultant does manifest a relatively disinterested attitude towards much of the clinical detail and process, but this disinterest should not be confused with the academic methodological stance of the watcher whose goal is to develop a specific knowledge or understanding rather than to aid actual clinical decision making.

Unlike the witness, whose goal and functions consist in reinforcing or ratifying a set of moral values as they come into question in a practice setting by directly participating in various ceremonies associated with the social definition of reality, the consultant functions within medicine as an identified expert

who functions independently to offer advice or recommendations in specific cases presenting ethical problems. As such, the practice of ethics consultation assumes the autonomy and competence of practitioners as well as the integrity of clinical medicine. Since the practice is not viewed, even implicitly, as in question—as it is in the functions of the witness—the consultant does not have to 'protect' the practitioners against external threats, does not have to reduce anxiety or reinforce group values. Rather ethics consultation assumes that practitioners are mature and self-critical and that problems and conflicts in the course of medical practice are amenable to rational analysis and decision making. Of course, anxiety reduction, reinforcement of group values, or protection from external threats may also be achieved by ethics consultation, but not as the primary goal.

Paradoxically, the very features that demarcate clinical ethics as an academic discipline, namely its claim to being a disinterested, discipline-based study of medicine, establish a basis for the claim of expertise and create difficulties for truly consultative functioning. Consulting cannot be done from afar, but requires a practical involvement in the clinical setting. Both the practical or 'clinical' involvement and the relation of this involvement to academic or professional qualifications have occasioned much consternation and debate. Under the rubric of 'applied ethics' or 'applied philosophy' these issues have been enjoined theoretically in terms of the nature of philosophical knowledge, the proper function and contribution of philosophical analysis or discourse, and the professional qualifications of the consultant.

Consultative activities have certainly evolved from and, no doubt many would argue, fit naturally as a component function of an academic appointed primarily to teach and to conduct research in medical ethics, but ethics consultation has also developed along a different line and in response to different interests and pressures. Recommendations of the President's Commission, decisions by various courts, and even the Baby Doe regulations have stimulated the establishment of hospital ethics committees and undoubtedly have encouraged the interest in and practice of ethics consultation. The developments have considerably complicated the picture [37].

ETHICS COMMITTEES

Except in rare circumstances, the committee structure seems ill-suited to carry out the tasks usually performed by individual consultants. Of course, the ethics committee can delegate responsibility to gather information such as interviewing the attending physician, patient, family members, or staff as appropriate or to review the medical record, but necessarily committee involvement complicates the process. At a minimum it usually formalizes the process of deliberation, and introduces procedural considerations or requirements. While concurrent review of troublesome cases by a hospital ethics committee can be conducted along the broad lines sketched above, it is also certain that many committee 'consultations' are more akin to quasi-legal or administrative review than clinical consultations. Similarly, retrospective review or after-the-fact consultation seems more like

routine teaching activities such as grand rounds or clinical case conferences than true consultations. It is important to remember that just as the term clinical ethics denotes a variety of activities so does ethics consultation, especially when viewed in terms of hospital ethics committee activities, is probably best regarded as a class composed of members that exhibit a broad set of family resemblances, but no logically sufficient defining features.

The development of hospital ethics committees is important for clinical ethics, because it introduces a new avenue into clinical ethics besides the traditional academic or educational appointment and because it highlights consulting as an aspect of clinical ethics. Committees composed of members who lack any (or who have very little specific) training in ethics are nowadays 'doing' clinical ethics alongside and sometimes in competition with more formally trained individuals. This commitment to practice naturally raises questions regarding the authority, expertise, and methodology requisite for ethics consultation; however, their complexity prohibits anything but a general treatment in the present paper.

Questions about the authority, expertise, and methodology of ethics consultation are aspects of a broader question, namely what legitimates clinical ethics generally. Because this question cannot be divorced from the component activities of teaching, watching, witnessing, and consulting, I doubt that an uncontroversial answer can be given. However, it is possible and important to indicate that the question of legitimation of clinical ethics itself involves three different, but nonexclusive aspects: legal, professional, and social accountability or authorization [38].

LEGMMATION

The question of legal authorization for clinical ethics depends on whether one is discussing teaching, watching, witnessing, or consulting. Teaching and watching do not seem to present special problems. In most cases, the clinical ethicist's academic appointment brings with it sufficient authorization. Whenever the clinical ethicist is engaged in formal research rather than teaching, however, the canons and regulations governing research with human subjects come into play, though it is not apparent that most clinical ethicists think of their observational interactions in the clinic as falling under these requirements. Since clinical ethics is usually part of educational programs, access to patients and patient records occur under the aegis of the educational mission; the usual methods of legitimating clinical educational activities such as peer review by curriculum or clerkship committees and consent of patients should apply here as well.

Witnessing represents a more difficult case largely because witnessing includes an array of activities or functions, some of which seem necessary for functioning in clinical or therapeutic contexts, yet which do not provide a basis for an independent legitimation of clinical ethics. A good deal of witnessing functions are carried out explicitly by practitioners such as pastoral counselors and clinical-liaison psy-

witnessing functions, pastoral counseling and clinical-liaison psychiatry present worthwhile comparisons for clinical ethics. The role of consulting can also be merged with aspects of the witnessing role, sometimes in a highly problematic fashion. One clear example is cases in which requests for psychiatric consultation are really pretexts for dealing with what are basically moral dilemmas in patient care as described by Mark Perl and Earl Shelp:

Sometimes nonpsychiatric physicians turn to their psychiatric colleagues for help and guidance with morally troublesome cases. In these contexts, psychiatrists are not necessarily seen as moral arbiters; rather, we believe they are regarded as experts in mediating and resolving conflict, both intrapsychic and interpersonal. The primary physician is often acutely aware of the patient's psychic distress and of the interpersonal tensions that accompany the medical-moral problems. *The psychiatrist is expected to fill a mediating role, often with a mandate to resolve the situation within a particular direction, to persuade the patient or family to act in a certain way.* In the process, unfortunately, a moral consideration of the proposed or expected actions and a consideration of the ethical dimensions of the case are often overlooked or ignored by both the primary physician and the psychiatrist [emphasis added] [39, 40].

Since witnessing functions necessarily include interactions that are ethically-charged, so to speak, these functions should be seen *as aspects of clinical ethics* and not as part of other therapeutic or quasi-therapeutic roles. The vagaries of the witnessing role thus makes it doubtful that witnessing can sustain an independent legitimation.

Consultative activities by far present the most serious, yet interesting problems of authorization. There is certainly a sense in which consultative activities are part of teaching and are closely affiliated with watching and witnessing. Despite this fact, it is important to distinguish the informal giving of advice and making recommendations that occurs in the course of teaching clinically and formal consultation. Formal consultations are part of most professional practices and are usually covered by licensure [41]. Physicians, nurses, psychologists, or lawyers who serve as consultants are licensed by the state to practice. Consulting is but one form of practice which is authorized by state-granted license. There is, indeed, something counter-intuitive about the notion of a state-licensed consultant in ethics, but the concept is not obviously self-contradictory. Presumably, licensure has evolved both to assure that a standard is maintained in a particular practice and that practitioners are assigned a specific and general legal accountability for their actions and omissions and specific privileges such as protection of confidentiality or the very basic privilege of engaging in the practice in question, but licensure is not the only form of legal authorization. Legal authority might also develop in a nonstatutory sense, through court decisions involving ethics consultants directly or through courts' reliance on individuals involved in ethics consultation as 'expert witnesses' (42,43). Of course, because something is not formally permitted or regulated by law, no implications follow regarding its legal prohibition or its ethical justification.

pitals or medical schools can create programs in clinical ethics. The effectiveness of such programs importantly depends on the degree to which clinical colleagues accept and support ethics teaching and consulting in the clinical setting thereby establishing a socially-derived authority for clinical ethics. Given society's enthrallment with legal authorization, this informal, socially-derived form of authorization is likely to pale in comparison. However, roles become effective not just because legislatures or courts explicitly require or permit certain kinds of activities, but because participants in the social setting in question actually support and make possible the enactment of roles. To be sure, legalistic requirements may make institutions and practitioners more receptive to clinical ethics, but it may also create a backlash that is especially relevant in the context of formalized ethics consultations conducted by hospital ethics committees.

At present, there is little evidence regarding the kind of social mechanisms that support clinical ethics. Everyone involved is likely to agree, however, that some network or system of support is essential, but what actually defines that support is presently more a matter of anecdote than data. Distinguishing the teaching, watching, witnessing, and consulting aspects of clinical ethics should be helpful in this regard insofar as the social authorization that occurs or fails to occur might be focused on one or another of these roles.

Finally, there is professional authorization, that is, authorization dependent upon professionally-recognized attainment of knowledge, skills, and proficiencies judged essential for clinical ethics. Such professional authorization might take the form of, for example, PhD programs in clinical ethics creating a subspecialty within the discipline of philosophy [44]. Or, recognizing that other academic avenues are available for access to clinical ethics such as graduate training in theological ethics or postdoctoral training in clinical medical ethics, an interdisciplinary professional certification might be more appropriate. Unlike either legal or social authorization which, in an important sense, are external, professional authorization is based upon the acknowledgement by peers that an individual has obtained sufficient levels of proficiency or credentials to be recognized as professionally competent. Typically, legal authorization, e.g. licensure, formalizes a process of professional authorization and social authorization also seems to rely, at least in part, on the possession of professional credentials. This observation explains why considerable uncertainty surrounds the status of clinical ethics today.

THE ISSUE OF EXPERTISE

Questions regarding professional or other authorization ultimately hinge on the question of expertise or qualification. Since it is widely agreed that there is no general consensus regarding the relevant theories and principles systematically defining ethics, anyone doing clinical ethics could not be said to apply such principles or theories in a fashion analogous to the way a clinical consultant might be said to normally apply a specialized knowledge [45]. Therefore, it is

frequently argued that the ethics consultant cannot be a specialist in the same sense as the typical clinical consultant, and clinical ethicists cannot provide authoritative advice, because they have no special technical expertise [46-48]. It is assumed that the expertise involved consists in the knowledge of ethical theory, the skills of ethical analysis, and, most importantly, the ability to deductively apply ethical theory to cases and practical problems.

Arthur Caplan has pointed out that this view of applied philosophy or clinical ethics seems to be based on a conception of ethics that is strikingly analogous to the model of nomological explanation that dominated the philosophy of science for many years [35]. Explanation on the nomological-deductive model was regarded simply as a matter of deduction from theory accomplished by supplementing laws and principles with the appropriate boundary conditions, bridge principles, and empirical descriptions. The process of explanation was to be carried out in a value-free fashion by individuals dedicated to the ideals of advancement of human understanding and scientific progress. This view, which Caplan has termed the engineering model of applied ethics, assumes that (1) there is a body of knowledge that persons can be more or less knowledgeable about; (2) this knowledge becomes applied by deducing conclusions from theories in light of relevant empirical facts; and (3) the deduction can and must be carried out in an impartial, disinterested, and value-free fashion [49].

In broad terms, this view of clinical or applied ethics is compatible with the roles of watching and traditional views of teaching, and probably draws considerable tacit support from these quarters. Both teaching and watching are committed to or dependent upon a body of discipline-based, objective knowledge that is defined in terms of a set of specific theories and principles. Such objective knowledge is often regarded as conferring a value-free or 'objective' orientation to reality. Hence, it is not surprising that applied or clinical ethics has been both defended and criticized in terms that give priority to objective, impartial watching. After all, watching is a natural extension of the traditional role of teaching that preserves important ties with the traditional academic and scholarly commitments of philosophy. It also preserves for the clinical ethicist a tie to an academic tradition and provides occasions for critical reflection on medical practice which are readily capable of being transferred (or applied, in a reverse direction) to theoretical research [50-52]. Neither witnessing nor consulting has these natural ties, a fact that is a source of embarrassment and anxiety for many academically-minded clinical ethicists.

The bias toward watching and teaching (and away from witnessing and consulting) has roots in twentieth century moral philosophy. Until recently, the view that there is no such thing as moral expertise and that moral philosophers are not moral experts was widely held, as Peter Singer has pointed out [53]. Even now, despite the prominence of bioethics and the important contributions that it has made to ethics and philosophy, skepticism about the possibility of moral expertise is expressed [54]. This skepticism is at least partly attributable to doubts about the legiti-

mate authority that a moral expert or clinical ethicist could claim. Such doubts, as already noted, are more helpfully expressed in terms of the question of authorization than theoretically as an issue of the justification of moral knowledge. Although these issues are too complex to be taken up here, it is interesting to note that discussion of these issues exhibits preconceived academic notions of what doing ethics consists in, notions which gravitate toward teaching and watching and away from witnessing and consulting.

For example, armed with a familiarity with moral concepts, training in the logic of moral argument, and the luxury of time to gather information and to think about moral questions—elements that Peter Singer regards as defining expertise in ethics—the applied philosopher is presumably supposed to function impartially and objectively in medicine. Nicholas Rescher has argued that the proper 'application' of philosophy is not in the substantive application of theories and principles to the solution of practical problems, but rather in the methodological clarification of problems:

there remains that other, less committed way of 'applying' philosophy where what is at issue is not the *substance* (results, findings) of philosophical inquiry, but its *methods*. In this methodological setting, we treat problems at arm's length rather than taking a committed position regarding their resolution. We delineate the issues, clarify the problems, pinpoint what questions must be decided, and examine what sorts of considerations must be taken into account. What is at issue here is a matter of problem-clarification, something which, useful though it is, stops well short of problem-resolution [12, p. 8].

The tension between these simplistic characterizations and the descriptive reality of clinical ethics developed above should be apparent. Caplan argues that in emphasizing technical ability and skills, the engineering model fails to actually take into account what those actually working in the field do [49, p. 13]—a point that can hardly be overemphasized. What those working in the field actually do, however, is a more complex phenomenon than is generally acknowledged.

THE PRACTICE OF CLINICAL ETHICS

What main features of clinical ethics stand out from the four roles just discussed? Two skills stand out beyond the technical skills mentioned above: moral diagnosis and reflective moral judgment. *Moral diagnosis* involves the ability to identify and classify moral issues and problems; it consists in the ability to discover moral problems or the ethical dimensions of practice where none were previously thought to exist. In sum,

the philosopher doing applied ethics should be able to (a) see moral issues others have missed, (b) anticipate the issues before they actually occur, and (c) properly classify the moral problems which arise in the ordinary ebb and flow of events in public and professional life. A knowledge of moral theories, traditions and concepts allows the moral philosopher to see the normative aspects of the ordinary events in ways that those are directly involved do not and sometimes will not [49, p. 141].

Clearly, to exercise these abilities the clinical ethicist must be situated close enough to the practice to be

intimately familiar with the everyday flow of events and yet sufficiently withdrawn to permit perspectival perception and critical reflection. In being able to identify and classify the ethical aspects of the practice, clinical ethicists bring a knowledge of traditions and theories which allow them to deliberate about and judge ethical matters in ways not available to the lay person [49, p. 15]. This does not mean, however, that the clinical ethicist *assumes* a given ethical theory, tradition, or world view and *applies* it to the given circumstances. The clinical ethicist is not simply a disinterested and objective observer able to judge from a privileged perspective; instead, the process involved is more complex.

In the first place; the clinical ethicist is actively engaged in the process of problem identification and solution. This means that he is primarily involved in the definition of the problem, in identifying the relevant facts and interpreting their significance for the problem at hand, rather than in the application of some moral rule or algorithm to settle the case. For this reason the clinical ethicist is better seen as trying to forge or create an ethic than simply applying one already formed. In so doing, the clinical ethicist is necessarily existentially engaged in the practice; he exhibits this engagement by being committed to a process of working to establish shared moral commitments [55]. Clearly, such a process is more compatible with witnessing or teaching than watching. How this process fits with the consulting role, however, is less clear. Certainly, a knowledge of moral concepts, traditions, and theories, is highly relevant if only in helping to interpret the concrete case. Utilizing such knowledge, however, must not be thought of as a technical matter of logically deducing or applying the relevant concepts, principles, or theories to particular cases or circumstances. Instead, a more complex process seems to be at work, a process that is similar to Aristotle's notion of *phronesis* or practical reasoning [56, 57]. This process involves *reflective moral judgment*.

Terrence Ackerman has argued that such reflection is central to clinical ethics and consists in first, analytic procedures useful in identifying courses of action that effectively respect shared moral priorities; second, since conduct in accordance with selective courses of action in specific circumstances might produce consequences which we either value or disvalue, moral assessment of the alternative solutions to a problem must include an understanding and accurate assessment of relevant facts or data; third, identification of alternative ways in which the problem might be resolved so as to allow the consultant to creatively fashion an alternative that respects relevant values; and fourth, a comparative assessment of how an alternative plan of action will achieve or fail to achieve states of affairs represented by relevant moral values [55, pp. 311-313].

The process of reflective moral judgment thus involves reflectively seeing and articulating moral issues in the welter of conflicting perceptions that characterize the clinical setting. So conceived, moral judgment involves sensitivity and thoughtfulness in

whether and how different relationships alter the duties and rights of affected individuals. And most importantly, reflective moral judgment seeks to identify solutions to moral problems which are actually effective in achieving moral priorities in practice [58]. Whether the teacher, watcher, witness, or consultant is best suited to meet these demands is unclear, but the conflicting tendencies in each of these roles for the task at hand also seems clear enough.

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- My analysis relies on the concept of a social role. Social roles serve to define moral duties for individuals and the kinds of actions that are morally permissible for individuals to perform in particular social settings. Significant social roles such as parent, physician, or teacher always involve complex layers of obligation' and correspondingly broad fields of action in which individual judgment is permitted within the defined role. The social role concept is significant, because it helps to define moral responsibilities for the role agent that are qualitatively different from the obligations of moral agents generally. For present purposes I do not discuss the theoretical problems associated with the concept of social role in ethics. Instead, I utilize this concept as a heuristic tool for clarifying some of the main problems associated with clinical ethics.
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- Freedman B. One philosopher's experience on an ethics committee. *Hastings Cent. Rep.* 11, 20-22, April 1981. 12.
- Appeal to objectivity and disinterestedness is also a prominent concern in discussions of applied ethics or applied philosophy. See, for example, Rescher N. Is philosophy a guide to life? (On the problematic nature of 'applied philosophy'). In *The Applied Turn In Contemporary Philosophy* (Edited by Bradie M. *et al.*), pp. 1-15. The Applied Philosophy Program, Bowling Green State University, Ohio, 1983.
- Day J. F. Some reflections on Professor Rescher's Paper. In *The Applied Turn In Contemporary Philosophy* (Edited by Bradie M. *et al.*), pp. 16-22. The Applied
- Jonsen A. Watching the doctor. *New Engl. J. Med.* 308, 1531-1535, 1983.
- Surely, Jonsen and others-myself' included- are not just watchers of the medical drama, but participants in the process of medical education and ethics consultation. Teaching is for many the primary activity. Admission to the clinical setting usually comes with the academic appointment-Jonsen's 'professing medical ethics'-though it is increasingly clear that there are other modes of access; for example, the appointment of what the job announcements call hospital ethicists, who might fill consultative or administrative functions first and education functions secondarily if at all. No doubt these developments challenge the traditional definition of the clinical ethicist in terms of teaching or watching. 16. Bosk C. The fieldworker as watcher and witness. *Hastings Cent. Rep.* 15, 10-11, June 1985.
- Bosk C. *Forgive and Remember: Managing Medical Failure*. University of Chicago Press, Chicago, Ill., 1981.
- Some who profess to be clinical ethicists seem to regard this as *the* proper function of clinical ethics. The tension that exists between pastoral counselors or physicians who teach ethics clinically and philosophers or others who are primarily specialized in ethics and who see themselves as academics rather than practitioners can be explained partly in terms of the affinity which practitioners find with the role of witnessing, but which some academics either reject in favor of watching (often articulated in terms of a preference for the academic activities of research or teaching) or about which they express serious doubt. Of course, this tension might also be seen as a case of fairly typical intraprofessional rivalry which deserves a separate treatment. It is important for present purposes because it reveals certain fundamental possibilities that are associated with clinical ethics generally, possibilities that do not conveniently sort along disciplinary lines. Even an academic who 'just' teaches ethics in a clinical setting and who is committed equally to research in medical ethics will find himself at times in a witnessing role.
- Schutz A. The stranger: an essay in social psychology. In *Collected Papers, Vol. 2*, pp. 91-105. Martinus Nijhoff, The Hague, 1964.
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- This is borne out, for example in the problematic 'sense of legal protection' which practitioners sometimes expect from the witness, but which the witness cannot legitimately supply. For example, Bosk reports being asked not to take notes and to forego obtaining informed consent from patients so that he might not be called as a legal witness against the practitioners in any ensuing lawsuit; this transforms the fieldworker into a servant to the practice who must protect practitioners even to the extent of infringing patients' right of informed consent. Clinical ethics involves similar ambiguities and problems. Bosk's article can be read as a reflection by a concerned and dedicated fieldworker on the moral paradox associated with the slide from watching to witnessing. As Kierkegaard S. *Either/Or, Vol. II*, p. 14. Oxford University Press, 1946, put it, "There is something treacherous in wishing to be merely an observer."
- Others discussing 'applied' philosophy and ethics also have tended to defend watching over witnessing at least implicitly by arguing for a cognitive or disciplinary basis independent of medicine as a practice. See for example, Baumrin B. H. The autonomy of medical ethics: medical science vs medical practice. *Metaphilosophy* 16, 93-102, April/July 1985.
- Branson R. Bioethics as individual *and* social: the scope of a consulting profession and academic discipline. *J. Relin Ethics* 3 111-139 1975.

24. Stevenson L. Applied philosophy. *Metaphilosophy* 1, 258-267, July 1970.
25. Agich G. J. (Ed.) The concept of responsibility in medicine. In *Responsibility in Health Care*, pp. 53-73. Reidel, Dordrecht, 1982 and Ladd J. Legalism and medical ethics. In *Contemporary Issues in Biomedical Ethics* (Edited by Davis J. W. et al.), pp. 1-35: Humana Press, Clifton, N.J., 1978.
26. It is interesting to note that as a group or a practice develops values and beliefs that are contradictory or at least in tension, members of the group seem unable to provide this authoritative function precisely because the tension between the group's conflicting beliefs and values undermines the authority of practitioners themselves to carry out the ceremonial or religious function. Hence the group actively seeks out or passively accepts outsiders or strangers to take on the priestly functions.
27. The following characterization of clinical consultation is generally drawn from Siegler M. Medical consultations in the context of the physician-patient relationship. In *Responsibility in Health Care* (Edited by Agich G. J.), pp. 141-162. Reidel, Dordrecht, 1982.
28. Avom J. A physician's perspective. *Hastings Cent. Rep.* 12, 11, June 1982 has put it: "We do not arrogate to them (and thus abrogate our own) responsibility for consideration of ethical issues. Instead, we utilize their expertise to sharpen the focus on these issues and clarify our own actions or potential choices."
29. In an article entitled, Ethics consultations in the hospital. *New Engl. J. Med.* 311, 983-986, 1984, Ruth Purtilo has noted that in clinical consultations sometimes the consultant's evaluation indicates that the consultant should assume charge of the patient's diagnostic or treatment regimen or that both the referring physician and consultant should share responsibility for patient care. She observes:
 However, the ethicist retreats after the consultation; under no circumstances would the outcome of an ethics consultation be that the ethicist became the primary caregiver or assumed ongoing responsibility for the clinical management of a case (although there might be additional consultations if other ethical problems arose).
 There is a *non sequitur* here. Of course, the ethics consultant will not assume the clinical management, but it is at least conceivable that an ethics consultant might assume the management of the ethical aspects of the case. For example, if further discussion with the patient, family, or staff is indicated, the ethics consultant seems particularly well-situated to arrange for and even to lead such discussion. That these occurrences are rare may have more to do with imagination and skills of the individual ethics consultant and the way in which ethical problems are conceptualized than with any necessary features of the role itself. Should such 'management' occur, the ethics consultant would nonetheless still function coordinately with the primary physician.
30. Recent work on ethics consultation has tended to focus on the consultative functions of hospital ethics committees, but even here the work is quite preliminary. See, for example, Youngner S. J. et al. A national survey of hospital ethics committees. *Crit. Care Med.* 11, 902-905, 1983.
31. Macklin R. Consultative roles and responsibilities. In *Institutional Ethics Committees and Health Care Decision Making* (Edited by Crawford R. E. and Doudera A. E.), pp. 157-168. Health Administration Press, Ann Arbor, Mich, 1984.
32. See the articles by Joan McIver Gibson and Thomasine Kirnbrough Kuschner; Susan Wolf, Alan Fleishman; Thomas Elkins et al.; Sheldon Berkowitz; and Mark Siepler in Ethics committees: how are they
33. Wilson Ross J. *Handbook for Hospital Ethics Committees* American Hospital Publishing, Chicago, Ill., 1986.
34. Albert R. Jonsen has argued that an ethicist can be a consultant insofar as he functions as a casuist, Can an ethicist be a consultant? In *Frontiers in Medical Ethics* (Edited by Abernathy V.), pp. 157-171. Ballinger, Cambridge, Mass., 1980.
35. Ironically, one reason why clinical ethicists seem reluctant to offer help in the course of teaching is that the suggestions that are often appropriate seem either obvious and trivial or relatively unconnected with what most would recognize as the proper domain of ethics. For example, Caplan A. Can applied ethics be effective in health care and should it strive to be? *Ethics* 93, 311-319, Jan. 1983, described how he ascended to the status of 'moral guru' by suggesting that Medicaid/Medicare might cover the provision of air conditioners for individuals suffering from respiratory ailments!
36. This point is admittedly controversial. Some have called for the physician to take over clinical ethics, particularly to conduct consultations; for example, Siegler M. Clinical ethics and clinical medicine. *Archs intern. Med.* 139, 914-915, Aug. 1979. The claim seems to be based on assumptions about the nature of ethical problems in clinical medicine (and perhaps the nature of ethics and ethical decision making generally), as well as the expertise or qualifications relevant to addressing these problems such as appropriate professional credentials. I take up these issues in a general way at the end of my paper with the primary intent of demarcating the lay of the land, so to speak, rather than constructing a defensible position.
37. Lo B. Behind closed doors: promises and pitfalls of ethics committees. *New Engl. J. Med.* 317, 46-50, 2 July, 1987.
38. Churchill L. R. The professionalization of ethics. *Soundings* 60, 40-53, 1977.
39. Perl M. and Shelp E. Psychiatric consultation masking moral dilemmas in medicine. *New Engl. J. Med.* 307, 618, 2 Sept., 1982.
40. See also, Hayes J. R. Consultation-liaison psychiatry and clinical ethics; A model for consultation and teaching. *Gen. Hosp. Psychiat.* 8, 415-418, 1986.
41. For an overview of the legal aspects of ethics consultation, see Robertson J. A. Clinical medical ethics and the law: rights and duties in ethics consultations. In *Clinical Medical Ethics: Exploration and Assessment* (Edited by Ackerman T. F. et al.), pp. 69-81. University Press of America, Lanham, Md, 1987.
42. McAllen P. G. and Delgado R. Moral experts in the courtroom *Hastings Cent. Rep.* 24, 27-34, Febr. 1984.
43. Delgado R. and McAllen P. The moralist as expert witness. *Boston Univ. Law Rev.* 62, 869-962, July 1982.
44. Cebik L. B. The professional role and clinical education of the medical ethicist. *Ethics Sci. Med.* 6, 115-121, 1979.
45. It is not at all clear that the model tacitly assumed in most discussions of applied knowledge or practical reasoning, namely the technical application of theoretical knowledge to practical problems and circumstances, is an apt understanding of the complex judgmental process involved. Nonetheless, in the present paper I simply accept the standard, if largely inchoate, view of these matters.
46. Sharkey P. There is no ACME in ethical consulting. *Philos. Med. Newsl.* 6, Fall 1986, has concluded from these kind of considerations: "there is no such thing as a 'Board Certified' ethical consultant-there is no 'American College of Medical Ethicists (ACME)'-nor should there be."

47. Other doubts have been expressed by Nielsen K. On being skeptical about applied ethics. In *Clinical Medical Ethics: Exploration and Assessment* (Edited by Ackerman T. F. et al.), pp. 95-115. University Press of America, Lanham, Md, 1987.
48. Young J. O. The immorality of applied ethics *Int. J. Appl. Philos.* 3, 37-42, Fall, 1986.
49. Caplan A. Mechanics on duty: the limitations of a technical definition of moral expertise for work in applied ethics. *Can. J. Philos.* 8, 8, 1982.
50. The tendency to view all problems as amenable to solution by experts or technical specialists also feeds into the view of the ethics consultant as expert in the application of abstract moral principles or rules to individual problem cases. No wonder, then, that this view of applied philosophy has been subject to political criticism on the grounds that applied ethics is a professional effort to usurp moral authority by abstracting issues from concrete social reality. See, for example, Noble C. N. Ethics and experts. *Hastings Cent. Rep.* 12, 7-9, June 1982.
51. Bennet W. J. Getting ethics. *Commentary* 65, Dec. 1980.
52. For reactions to Cheryl Noble's criticism of expertise in ethics by Peter Singer, Jerry Avorn, Daniel Wikler, and Tom L. Beauchamp as well as Noble's reply, see *Hastings Cent. Rep.* 12, 9-15, June 1982.
53. Singer P. Moral experts. *Analysis* 32, 115, 1972.
54. This general problem forms a background for much of my discussion. My own view is that a more secure to the general issue of applied ethics can be gained by shifting attention from worries about justification conceived in terms of the model of applying theoretical knowledge to practical problems to a consideration of the justification of the actual practice of doing applied or clinical ethics. To make this shift possible, however, a better understanding of the actual practice in question is necessary—an obvious point perhaps, but one which is often forgotten in much of the debate over these matters.
55. Ackerman T. F. The role of an ethicist in health care. In *Health Care Ethics* (Edited by Anderson G. R. and Anderson V. A.), p. 314. Aspen, Rockville, Md, 1987.
56. Larmore C. E. *Patterns of Moral Complexity*, pp. 1-21. Cambridge University Press, 1987.
57. Jonsen A. R. and Toulmin S. *The Abuse of Casuistry*. University of California Press, Berkeley, Calif., 1988, argue for a case-oriented approach in practical ethics that they identify with the historical tradition of casuistry.
58. Ackerman stresses that this view about the purposes and procedures of moral reflection does not assume that achieving closure on all moral issues is possible. However, lack of complete success in resolving all moral problems does not undermine the usefulness of the methodology. Rather, the crucial question concerns which conceptualization of the process of moral reflection permits the *most effective* resolution of clinical ethical problems [55, p. 313].