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Clinical Ethics Consultants are not "Ethics" Experts—But They do Have Expertise[1]

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The attempt to critique the profession of clinical ethics consultation by establishing the impossibility of ethics expertise has been a red herring. Decisions made in clinical ethics cases are almost never based purely on moral judgments. Instead, they are all-things-considered judgments that involve determining how to balance other values as well. A standard of justified decision-making in this context would enable us to identify experts who could achieve these standards more often than others, and thus provide a basis for expertise in clinical ethics consultation. This expertise relies in part on what Richard Zaner calls the "expert knowledge of ethical phenomena" (1988, 8).

Keywords: *clinical ethics consultation, ethics expertise, will to believe*

> Objective evidence and certitude are doubtless very fine ideals to play with, but where on this moonlit and dream-visited planet are they found?
>
> —William James (1912), "The Will to Believe"

> The discovery that truth is not monolithic does not really leave us in a skeptical, relativistic welter, because the various patterns overlap and can be related to each other. But it does mean that we need to view controversy very differently. An immense proportion of academic time, paper and word-processing power is used on battles between models both of which have their place, instead of on quietly working out what that place is and how to fit them together.
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> —Mary Midgley (1992), "Philosophical Plumbing"

I. "WHAT OUGHT TO BE DONE?"

Although the field of clinical ethics consultation has wrestled with the question of whether or not to give advice or make recommendations in clinical

ethics cases, worries about overstepping the field's warrant by making recommendations seems to have lost out to a more official stance in favor of the practice.[2] Moreover, ethics consultants have pointed out that refusing or failing to make recommendations is a sure way not to be consulted again. Consequently, one of the tasks a clinical ethics consultant can be expected to perform is to offer recommendations regarding what ought to be done in a clinical ethics case.

The fact that others want recommendations is insufficient to justify those that are given, however. After all, if there are no justified reasons to consider the recommendations of clinical ethics consultants, the right response might be to cease the practice altogether. Instead, practitioners should establish and disseminate clear answers to some foundational challenges to the practice of clinical ethics consultation: What is the expertise of clinical ethics consultants that warrants respect for their recommendations? In what way is a claim about "what ought to be done" justified, and what follows from that?

I argue that expertise in clinical ethics consultation is expertise in making morally relevant decisions in complex clinical contexts. These decisions do not involve only ethical values, and so do not require ethics expertise of the kind critics assume in challenging the practice of clinical ethics consultation. Clinical ethics consultants can come to exhibit what Richard Zaner called the "expert knowledge of ethical phenomena," among other things, but they should not claim expertise in a universally accepted moral foundation, and their recommendations will not be justified with certainty (Zaner, 1988, 8).

II. CLINICAL ETHICS CONSULTATION AND THE NEED FOR STANDARDS OF EXPERTISE

Questions about the expertise of clinical ethics consultants are raised in at least three ways. First, when clinical ethics consultants offer advice and make recommendations, others might disagree with those recommendations. In such situations, one might ask what, if anything, makes the consultant's recommendation more compelling than anyone else's? As Dien Ho puts it, what accounts for the epistemic asymmetry between an expert and a layperson (or one expert and another) (Ho, 2016)? Put this way, what is desired is a means of adjudicating between two incompatible recommendations or of identifying a legitimate versus an illegitimate recommendation. A standard of expertise could help to make such distinctions by explaining the expertise consultants possess, the knowledge that contributes to it, and the way these justify both the general practice and the particular judgments the practitioners offer.

Second, clinical ethics consultants are in the process of professionalizing (Kodish et al., 2013). Since a hallmark of a profession is its unique set of

knowledge and skills—the expertise that defines the profession and identifies excellent and poor practitioners of it—consultants aiming to professionalize must articulate the special set of skills, knowledge, or expertise possessed by clinical ethics consultants. This account should help to identify future practitioners, enculturate trainees, explain to users of the service just what they should be able to expect from competent practitioners, and explain to employers what they can and cannot ask of consultant-employees in terms of expertise. This is not framed as a challenge for justification, but instead this is framed as a need to constitute the backbone of the field—what makes the practice a "this," recognizable by others, rather than the hobbyhorse of a few individuals.[3,4] A standard for identifying expertise in clinical ethics consultation could achieve both goals.

Third, consultants themselves have reflected on the discomfort they experienced on entering the field. Making a pronouncement in clinical ethics consultation can feel audacious to a consultant with at least a modicum of humility.[5] They might wonder just what they are doing and what could possibly justify their recommendations.

These are ultimately challenges to the legitimacy of the field. A responsible profession must be able to articulate the standards by which the competence of its members can be evaluated. If clinical ethics consultation fails to do so, a variety of responses are reasonable. First, both those who use the profession's services and those who pay for the employment of its members may harbor skepticism about their recommendations in individual cases: what makes the judgment of an ethics consultant better than that of a family member, healthcare provider, or lawyer? Second, members of society who view the profession from a distance may suspect that it imports ideological Trojan horses into the healthcare setting by falsely presenting one moral perspective (their own) as universal. Consultants who maintain a healthy self-skepticism may also wonder whether their recommendations are warranted in the absence of any standards of success. Without a standard of expertise, a profession risks hostility, ridicule, lack of support, and, ultimately, demise. Clinical ethics consultation must articulate a robust account of the expertise that it can offer.

Expertise is usually taken to be a holistic assessment: an expert is someone who, on the whole, is better than most people along some particular dimension. Chess grandmasters win more tournaments than others, on the whole, even if they do sometimes lose. Expert surgeons are better able to perform difficult surgeries and/or have better success rates on surgeries in general than do others (not to mention being better than laypeople at surgery), even if they sometimes make mistakes. Expert investors may be able to identify potential investments faster or more reliably than others, even if they do not make ideal investments in every instance. Identify a task or area that admits of degrees of success, and experts are those whose overall performance is better than others'. Someone is usually not labeled an expert after just one

success, no matter how significant; expertise requires successful iteration of a task. Labeling someone an expert therefore involves being able to identify what constitutes success in some particular area.

What expertise justifies clinical ethics consultation? The most pressing critique of the field is the one that challenges the ethics expertise of consultants—that is, the claim that consultants can be experts in ethical decision-making.[6] The typical move in this argument is to observe the fact of moral pluralism and the difficulty of securing universally accepted moral foundations and conclude that we lack standards acceptable to all that would identify ethics experts. The obvious implication is that, therefore, the main task of clinical ethics consultation is indefensible.

For many years, the question of ethics expertise was more theoretical than practical. Authors like Cheryl Noble (1982), Bruce Weinstein (1994), and Scott Yoder (1998) generally analyzed what expertise in ethics could mean in the abstract and defended or critiqued the various possibilities. However, as David Rothman's *Stranger at the Bedside* (Rothman, 1992) chronicles, the appearance in hospitals of non-clinicians whose advice was sought in (or who inserted themselves into) clinical cases involving ethical tradeoffs, uncertainties, or conflicts changed the way medical decisions were made. This in turn provoked increased attention to the issue of ethics expertise in clinical ethics consultation.

III. ETHICS EXPERTISE IN CLINICAL ETHICS CONSULTATION

There is substantial agreement that clinical ethics consultants can be ethics experts in the sense of "facility with moral theories and arguments." After all, we regularly trust professors of moral philosophy to teach students moral arguments and critiques. But in clinical ethics, more than this is usually desired: we seem to expect an expert to be right about her claim regarding "what ought to be done," or at least for her answers to be better than those of the average person in some identifiable way (these are not necessarily the same thing).

This implies that recognizing expertise in ethical decision-making requires recognizing success in ethical decision-making. The ethics expert is someone who succeeds in making an ethical decision more often than the non-expert. The assessment of success in ethical decision-making is thus usually taken to be an assessment of the meta-ethical foundations of ethical decision-making, because it seems to be necessary to establish what constitutes a "right" decision before we can establish who is an expert in that. This is why the conversation about ethics expertise in clinical ethics consultation is so difficult: the positive identification of experts in the field seems to depend on the conclusion one draws from a debate about the foundations of morality that has endured for thousands of years.[7]

Because of this still-contentious debate, critiques of clinical ethics consultation often challenge the possibility of universal moral foundations, and with it the possibility of ethics expertise in a morally pluralist society. For example, as Engelhardt argues, given different understandings of "moral premises, rules of moral evidence, and rules of moral inference and/or of who is in moral authority to resolve moral controversies" in a pluralist society, we will be unable to justify claims to objective moral authority by sound rational argument (Engelhardt, 1996, 40). The fact that we lack universally accepted moral foundations means that there cannot be universal ethics expertise, and by extension, the profession of clinical ethics consultation lacks the core expertise that it claims.

The success of this critique depends on whether clinical ethics consultants claim the kind of universal ethics expertise described. In fact, I think it is a straw person argument, usually assumed without defense. As I have argued elsewhere, critics have not presented evidence that clinical ethics consultants in fact make such claims, and no official stance on the nature of ethics expertise in clinical ethics consultation has been offered (Rasmussen, 2011, 649–50). However, with the invocation of "ethics" in the title of the field, there is at least a suggestion that its practitioners can offer moral guidance, so the challenge must be addressed.

A frequent premise in critiques of clinical ethics consultation has been that some form of ethics expertise is required in order to justify the practice or to justify the recommendations offered. Because the guidance sought from such consultants is normative guidance—that is, guidance regarding what ought to be done—the conclusion drawn has been that clearly, the role involves some sort of moral expertise. But, notice the equivocation this involves: normative guidance is equated with moral guidance. The hidden assumptions are that any decision that involves value judgments is an ethical decision and that the expertise in clinical ethics consultation must be ethics expertise.

However, it is false to equate normative guidance with ethical guidance, so we have been mistaken in thinking that the expertise in clinical ethics consultation is ethics expertise. Clinical ethics decisions are all-things-considered judgments. They surely involve "ought" claims and value judgments, but they are rarely, if ever, merely moral decisions unless we assume that moral obligations always override or eliminate all other obligations or that any decision based on value judgments is also a moral decision. Frequently, decisions involve balancing a number of competing considerations, including legal, financial, psychological, interpersonal, or other factors. Morality is but one among many other considerations, and making a decision requires determining how to weigh some values (not just moral values) against others.

As a result, judgments in clinical ethics consultation cases (perhaps the name ought to be changed) are not—cannot be—justified by a meta-ethical argument about the correct foundations of morality, even if they were available. We need to pursue a different standard of justification for such

decisions. If we can articulate that standard, then we can assess what expertise in such a standard would look like. Only subsequently could we identify the best mechanism to provide that expertise to individuals who want it, but clinical ethics consultation as it is currently practiced offers one possible mechanism. First, however, it is worth considering our current approach to decision-making to ascertain whether such expertise is even necessary.

IV. DEFAULT TO INDIVIDUAL DECISION-MAKING

One response to the dilemma of moral pluralism is to create a procedural solution that enables decisions to be made in a pluralist society without assuming a shared meta-ethical foundation. Under the procedural solution, the requirement that ethical decisions must be objectively justified is waived in favor of allowing individuals to make decisions based on their own notions of justification. This results in a default to individual decision-making understood as "respect for autonomy."[8] The starting point is the individual's right to make whatever epistemological, metaphysical, or moral choices he deems wise under the circumstances. This interprets ethics expertise as an individual, subjective standard, in which individuals are understood to be ethics experts for themselves and as regards their personal conceptions of morality. The individual, after all, will have to live with the consequences of his decisions.

This approach has obviously met with tremendous success in the healthcare setting: in the United States and many other democratic countries, consent of the patient (or surrogate when necessary, understood as the historian of what the patient would want were he competent to decide) is required prior to treatment or research. It has been so successful, in fact, that the approach is critiqued for going too far and fetishizing respect for autonomy to the detriment of other important values.

But as important as that respect for autonomy is, there are many cases in which it is not enough to yield a merely procedural decision when a decision must be made. This reintroduces the need for standards of justification. First, patients sometimes lack capacity to exercise their autonomy. Although our commonly-recognized solution to this is to recognize a surrogate to make decisions for the patient, this step will itself often require making value decisions: if there is no legally appointed or identified surrogate, who should speak for the patient? What if we have reason to doubt the appropriateness of the surrogate, due either to his motives or his ability to represent the patient's interests? Nonobjective values will be required to make these determinations.

Second, the values of the patient can conflict with others who are affected by the decision, and a decision must be made regarding whose values win out in such cases. For example, if a patient wants everything done or wants to be allowed to die, healthcare providers and family

members may have different priorities but may be required to suffer the consequences of the patient's wish. Often those conflicting desires can both be accommodated, but sometimes they cannot, and a decision must be made about which values should be decisive. More broadly, the choices that individuals make often require resources of time, energy, and money from others. A clinical ethics decision is almost never only about an individual and her wishes.

Third, there are cases in which even competent patients are unsure of what their foundational values are, of what these values imply in a given case, or of how to navigate the many consequences of their decisions (legal, financial, moral, medical, etc.). They may also lack the kind of relationship with others who can offer loving advice, or they may have such relationships but also desire input from others who have more emotional distance from the situation.

Finally, the very determination of which choices should be presented to an individual to begin with is made before taking the individual's preferences into consideration. For example, resource allocation decisions, governing law and policy, and comprehensive sociopolitical structures (e.g., capitalism versus socialism) all contribute to controlling the constellation of possible choices individual patients can make on the basis of their certain moral views. Thus, for many reasons, the default to individual decision-making, although important in many societies, does not always result in a procedural, morally contentless process for establishing what ought to be done.

Although I do not believe there are, let us suppose that there are remedies for these kinds of cases that do not involve assuming a nonuniversal standard of justification. There are still problems with the very basis of the default procedure itself, if we are trying to avoid making decisions based on value judgments that not all share. First, the premise that individuals are the starting point for moral consideration is a substantive moral value that not all necessarily share. Even if in most cases we all agree that the patient's wishes should trump, that is still a value-based decision and not a mere procedural default. For example, Ruiping Fan has argued that "reconstructionist Confucianism" supports a family-oriented approach to informed consent (Fan, 2010, 2011, 2015).

Second, the determination of when an individual decision must be respected is itself not value-free. It requires establishing (on the basis of nonobjective value claims) who counts as a person and what counts as a competent decision. A tricky fact of assessing competence and the authenticity of decisions is that some choices seem themselves to present evidence of less-than-complete autonomy. A simple example of this is a patient who states a preference for one thing but makes choices inconsistent with that. A more complicated example is the patient who may express a choice but be unable or unwilling to offer any motivation for that choice. Among the most challenging cases are those in which a patient chooses on the basis of values we cannot understand within our own frameworks. For example,

if a female patient defers to her husband's choice regarding her fate, some may believe that her submission is evidence of lack of autonomy and thus a reason for disregarding her choices. Here, a nonobjective moral judgment must be made about the conditions under which we must respect individual decisions that avoid paternalism.[9]

Therefore, the procedural solution fails if the aim is to avoid making moral decisions that assume substantive values. Adopting a default to individual decision-making assumes from the outset a value not universally recognized, and it can often result in a situation in which a decision must be made without reference only to one individual's wishes, even the patient's. This is, in fact, our contemporary situation in the United States and many other countries: individual decisions are in most cases taken to trump the opinions and wishes of others, but sometimes this default still does not give us what we need to make a decision without assuming values that are not universally shared. We still need a pluralist account of successful ethical decision-making.

Notice that this discussion, begun with a consideration of the rights of individuals to make decisions regarding their own lives, has concluded with the observation that "we" need a pluralistic account of successful ethical decision-making. This is true because it is almost never the case that individuals make decisions that affect themselves alone; others bear consequences of those choices and perhaps may even be forced into complicity with choices they do not endorse. Except in the rare circumstance where everyone involved in a decision shares a moral foundation, decisions in clinical ethics consultation will be made in conditions of pluralism and collective uncertainty. If we lack a standard for identifying when decisions made under such circumstances are justified, we lack it for anyone—including healthcare providers—involved in such decisions. So, quite apart from the need to defend the field of clinical ethics consultation, we actually need a general account of good decision-making in clinical ethics cases by anyone.

V. AGAINST CERTAINTY

What counts as a justified clinical ethics decision? I have already argued that clinical ethics cases involve more than just ethics, and therefore, it is not meta-ethical justification we should be seeking. Standards of justification for clinical ethics cases must be articulated within the context of these cases. Theories or principles may present abstract, possible values for consideration, but they cannot help us make a *certain* decision. As Zaner helpfully articulates the problem, philosophers (one kind of clinical ethics consultant) can easily acknowledge the multiplicity of possible moral viewpoints or foundational principles, but the clinical practitioner faces "a wholly different problem: Which, among the competing principles, is the one that ought to

be applied in a particular case?" (Zaner, 1988, 12). Even if a principle can be chosen, he observes, "no physician [or, we might add, consultant] faces a series of clear givens.... An appeal to beneficence...cannot of itself tell the physicians how to act when matters are not clear or certain—how to weigh the probables and possibles, the ambiguities and uncertainties, so as to reach an 'ethically permissible' recommendation" (1988, 15). A patient's actual relationship with a friend, a family's internal logic or history, or an individual's quirky or asocial preference may be the most important factor in a particular case, and this cannot be captured in every instance by theory, principle, creed, or default to individual decision-making. Clinical ethics cases are each sui generis, though they may share important features. Medical or legal uncertainty may prevent anyone, including the patient herself, from establishing with certainty what, all things considered, ought to be done, particularly when there are consequences for others.

Acknowledging this context allows us to reframe the issue: The justification for a particular clinical ethics decision has to be understood within a context of uncertainty. Here, William James may help us to elaborate the conditions under which clinical ethics decisions are made.

William James and the "Will to Believe"

It is worth recalling a fundamental fact about clinical ethics consultations: often, a decision must be made, usually under the pressure and constraints of time. We cannot avoid deciding or wait until we achieve certain justification for a decision. Clinical ethics consultation involves what William James called a choice between forced, momentous, and live options. In "The Will to Believe," James describes his task as "something like a sermon on justification by faith.... a defence of our right to adopt a believing attitude in religious matters, in spite of the fact that our merely logical intellect may not have been coerced" (James, 1912).[10] His argument is not limited to religious concerns; it also applies to the question of what one ought to do in conditions of uncertainty, where greater certainty is elusive or impossible. This is precisely where clinical ethics consultation in a pluralist society is situated.

James argues that when we face a choice, we have options of different sorts: living versus dead options; forced versus avoidable options; and momentous versus trivial options. Living options present us with a genuine choice between two options that are plausible options for us, whereas dead options present us with a choice between two implausible options. Because their possibility is relative to the individual considering it, "live" options are not universal. In clinical ethics, think of an option between having an abortion to save one's life or continuing a pregnancy and accepting mortal risk. Either option might not be taken as a live option for certain patients, but it could be recognized as a live option by others; this difference in perspective is a common source of ethical tension in the healthcare setting.

Forced options present us with a choice that must be made because the options are "based on a complete logical disjunction, with no possibility of not choosing," in contrast with options both of which are avoidable (James, 1912, §I). Clinical ethics decisions are often forced because not choosing is choosing when the physiological clock is ticking. ("Letting nature take its course" is not avoiding choice, though psychologically we sometimes tell ourselves that it is. It is choosing not to undertake a particular intervention that may alter the outcome.)

Momentous options involve choice in a condition of great significance, whereas situations involving trivial options will have little repercussion no matter what choice is made. Decisions in the healthcare setting are often momentous, because the choices faced (particularly those that bring an ethics consultant into the picture) often involve consequences of morbidity or mortality.

James's framework is well-suited for understanding decision-making in clinical ethics consultation. As he argues, "[i]n all important transactions of life we have to take a leap in the dark.... If we decide to leave the riddles unanswered, that is a choice; if we waver in our answer, that, too, is a choice" (James, 1912, §X). In clinical ethics cases, we often cannot be certain, but we must nonetheless choose, making a leap in the dark. What counts as a justified decision in such circumstances?

The procedural default to individual choice is useful in beginning to answer this question: precisely because such decisions involve a leap of faith, the individual who will land after the leap has the most at stake. Her decision should be respected. But as we also know, sometimes a person is not competent to make a decision. Sometimes, too, we have to decide whether she is or is not, and that decision itself needs to be justified. And sometimes individuals do not know what they want, and they want recommendations regarding what ought to be done. I agree that individual decision-making should be the default, but that does not absolve us from articulating what to do when it cannot be, or, more tendentiously, when we refuse to recognize that it is appropriate in a given circumstance. It is clear that in pluralist societies, there is no shared certainty to be had. It is also clear that even a default to allowing individual decision-making assumes values from the outset and frequently requires judgments in individual cases as well. For the majority of human societies that accommodate pluralist values, then, we still require a standard for recognizing a justified ethical decision under conditions of pluralism and uncertainty.

The Problems With Certainty

A frequent assumption is that only absolute certainty would justify an "ought" statement. Justifying ethical decision-making without certainty is problematic in many ways. When confronting incompatible moral recommendations, we cannot establish which recommendation is correct without making

assumptions that not all share. In the absence of shared certain foundations, we seem to be reduced to radical relativism or nihilism in our dealings within a pluralist society. Making (and making sense of) moral claims and moral behavior seems to require meta-ethical foundations known with certainty.

However, the requirement for certainty in ethical decision-making is itself problematic. There is deep and abiding pluralism and disagreement about these foundations, and no reason to think this will ever change. Between a devoted religious believer and a liberal cosmopolitan atheist, not only might there be disagreement about the moral permissibility of abortion, there might also be disagreement about how to resolve the disagreement. A religious believer might advocate for prayer, in the hope that the atheist will be awakened to the truth. The atheist, for his part, might advocate a modus vivendi, for example, that both parties be ruled by the results of a democratic process, or by the judgments of an authoritative secular body such as the Supreme Court. Neither option is likely to satisfy a suitably trenchant opponent. As a practical matter, this deep and abiding pluralism seems, at least under requirements for moral certainty, to render any conversation about moral choices and behaviors nearly pointless unless it is conducted with someone with whom one shares a complete and robust set of foundations, but awaiting the acceptance of universal moral values is not a possible approach for pluralistic societies.[11] Worse, it suggests the likelihood of violence: as James put it, "When, indeed, one remembers that the most striking practical application to life of the doctrine of objective certitude has been the conscientious labors of the Holy Office of the Inquisition, one feels less tempted than ever to lend the doctrine a respectful ear" (James, 1912, §VI). Certainty is itself a value-based position (i.e., that certainty is the proper standard for justifying value claims) that requires a defense not usually offered.

Second, actual moral choices will involve interpreting what a set of foundations implies for a particular, concrete, and complex situation, and this interpretation will itself involve meta-ethical assumptions lacking foundations.[12] So, even if we wanted to rely on meta-ethical foundations, they would be inadequate to the task of providing answers to many concrete ethical dilemmas that can be justified with certainty.

The problem with the frequently-traveled path of searching for certainty in ethical decisions is that it leads nowhere—or at least, it leads to no other foundation than those the assessor has already accepted. This is true because establishing what counts as a certain moral claim requires the articulation of a set of meta-ethical axioms under which certainty can be had. For example, those in a particular religion may understand certainty to be had only by an authority under certain circumstances: the Roman Catholic Pope speaking ex cathedra, a mystic speaking in a trance or in tongues, or a psychic using tarot cards. Others may understand certainty to be only what follows from a logically sound argument. Each of these axiomatic starting points will not satisfy all of these groups; certainty can only be had within a set of foundational

axioms. Yet a pluralist society usually depends on some interaction between communities, and those interactions will be based on values that the communities do not necessarily share.[13]

It is important to remember that equating "knowing what ought to be done" with "knowing what is justified with certainty" is stipulative. That is, it assumes without defense a particular and contestable understanding of what counts as a justified knowledge claim. This absolutist, rationalist understanding of knowledge and justification can be challenged in several different ways. Feminist epistemology, for example, challenges the claim that the only true "knower" is the knower situated objectively and at an emotional distance from what is observed. The equation of "knowledge" with the adjective "certain" is difficult to resist, but it can be resisted—they are not synonymous.[14]

VI. JUSTIFICATION FOR CLINICAL ETHICS DECISIONS IN CONDITIONS OF UNCERTAINTY

The benefit of having certainty in our decisions would be that it might justify forcing others to act in particular ways, because by definition disagreeing with certain conclusions would be irrational. As I have argued, there are problems of several sorts with requiring certainty: it is a defeasible assumption; it is an impossible standard in and of itself; and it cannot provide the basis for recognizing justified decisions in conditions of pluralism. Our choices could be made on the basis of whim—flipping a coin, picking something without reason, sitting still and letting the choice "happen" to us, etc. But that amounts to making a bad choice, because, though we may not feel as though our choice matters at the moment, the fact is that whatever happens, our choices will have effects on us and for us. Though we do not care in the moment, our selves of tomorrow may care.[15,16] We must choose, in the absence of certainty, knowing that consequences may follow for ourselves and others. Unless we embrace relativism or nihilism (positions with their own problems), there must be better and worse ways of making such a decision, even if we cannot be certain about such conditions. If there are, there must be people who are more reliable at making better decisions than others. If so, then those will be the grounds for identifying expertise in clinical ethics decision-making and justifying the field of clinical ethics consultation.[17]

Claims to ethics expertise can be justified without appeal to certain foundations—though it is true that they will not be justified with certainty. The best that we will be able to do is reason our way to one or more acceptable conclusions in the best way we know how. I am not sure that we could ever offer a model of justified decision-making that would work in every context. But, such a pursuit is precisely what I am arguing against. Reaching a decision in complicated contexts can only ever be a "muddling through," and the muddling through is inexorably context-bound and improvisational.

The context of decision-making in clinical ethics cases is fairly well understood. Although novel issues arise from time to time, we have a sense of the factors typically present in such cases, even if we cannot know how to weigh those factors against each other. In such a context, one condition of justified decision-making is ensuring that the right kinds of questions have been asked. For example, a bad decision could be made on the basis of unjustified empirical claims (e.g., "X won't cause suffering") that can be successfully corrected by investigating whether that claim is well-founded. Ignoring power asymmetries, socioeconomic issues, or cultural issues in the case could also lead to bad decisions.

Thus conceived, a considerable part of ethics expertise in clinical ethics consultation is thoroughness. I have argued (Rasmussen, 2015a; paper in preparation) that thoroughness in clinical ethics consultation can be captured in a checklist. Such a list is designed to prompt inquiry into certain areas that must not be overlooked, and it implicitly assumes that gathering the requisite information will often help lead to a decision. Justification in clinical ethics consultation decisions could be offered at least partially by formulating a list of important factors that go into clinical ethics consultations and demonstrating that one investigated them.[18]

This justification is quite prosaic. It is not enough to overrule the contrary wishes of competent patients. But, I think it is the best we can do in this kind of circumstance when what we need is to understand how to make good decisions in conditions of uncertainty.

If this justification were successful, it would also provide the basis for assessing the claims of expertise of clinical ethics consultants. Under this conception of successful and justified decision-making, we can identify experts by assessing who succeeds at ensuring that the right information is sought and established. Perhaps in an ideal world, a patient's physician would exhibit this expertise and clinical ethics consultants would not be necessary. But for a variety of reasons, the physician often is unable or unwilling to play such a role. For example, he may be unable because of time constraints or lack of training in the nonmedical aspects required for fully considering the case.[19] So, while clinicians can certainly be ethics consultants and possess the required expertise, they are not the only ones who can. This provides the space for clinical ethics consultants.

It is not the fact that they can offer meta-ethical certainty, but rather the fact that they can help decision makers make better decisions that grounds their expertise. There are factors known to be frequently important in clinical ethics consultations, and experience with them can yield what Zaner called the "expert knowledge of ethical phenomena" (Zaner, 1988, 8). But that expertise has significant limits; it does not convey certainty. Thus, clinical ethics consultants should also render the bases of their recommendations transparent, and above all, no clinical ethics consultant should ever represent her judgment in a full consultation as definitively right, because that is a standard the circumstance will not allow.

VII. CONCLUSION

Clinical ethics consultation is never merely about ethics, unless almost every decision is an ethics decision. Thus, the legitimacy of clinical ethics consultation does not depend on articulating how to understand ethics expertise under conditions of moral pluralism. The expertise that clinical ethics consultation can offer is expertise in making all-things-considered judgments within a certain context. This context includes the consideration of local practice, legal proscriptions, hospital policy, and the contingent features of the actors and stakeholders in the situation. It is true that this claim to expertise requires articulating the standards of justification for such judgments, but that is required of anyone who makes or aids in making clinical ethics judgments. Although we usually recognize the right of individuals to make decisions regarding their own fates, that recognition still leaves many cases in which a decision must be made, and in some of those cases, help in thinking through decisions is welcome.

This is an essay about how to justify decisions in the face of uncertainty—which, I submit, is always. I reject the claim that justification can only ever be certain. Justification can consist of making the best decision we can under the circumstances: we can articulate some of the ways better decisions can be made, and we can identify people who are experts in reaching better decisions. None of these suggested solutions may be ideal or perfect. This is often thought to be a fatal flaw, but it is only a flaw, and only fatal, on the assumption that justified decisions must be certain and absolute. I am arguing that decisions made in clinical ethics consultation (and much of life) cannot achieve certainty, and thus do not require certain justification.

NOTES

1. In a previous paper, I argued for a model of ethics expertise for clinical ethics consultation (Rasmussen, 2011). However, I now recognize that the expertise involved is perhaps not best termed "ethics expertise," for reasons I articulate in what follows.

2. "The ethics facilitation approach does not preclude making recommendations as an ethics consultant. On the contrary, specific recommendations are often very helpful and appropriate. … However, consultants should be careful about recommending a single course of action if more than one course of action is ethically acceptable" (ASBH, 2011, 8).

3. Such an account may be used for other justificatory purposes, for example, to justify paying a consultant's salary. Although related to the larger question of justification of individual judgments, it is not the same justification, and it is really a secondary concern.

4. As Zaner quotes Callahan, in the early days of clinical ethics consultation, "there was 'a sense that much of what is labeled "ethics" represents a casual and irresponsible mischief-making, led by people with little understanding of research or practice'" (Zaner, 1988, 10).

5. As Zaner puts it, "…many of us felt acutely out of place and recoiled in shock and dismay. Our reaction often was that this is simply no place for a philosopher, whose training and disposition include nothing that could prepare one for rendering judgments, much less definitive, possibly irreversible, moral decisions" (1988, 5).

6. I will use the terms "ethical expertise" and "moral expertise" interchangeably.

7. There are other arguments against ethics expertise, for example, based on the moral need for autonomous moral decision-making (Driver, 2006) or the negative effects of ethics expertise on decision-making in a democratic society.

8. One interpretation of respect for autonomy is that it is a robust, intrinsic value, the ethical good of respecting individuals. A different interpretation is that this is not an intrinsic good, but is merely a side-constraint. The first involves value judgments from the outset and is thus not merely procedural. The second can be offered as a step without values initially, but interpreting when the condition is met will also require value judgments, so it is not a value-free procedure in practice. See Iltis (2015) for a comparison of these two approaches to autonomy in the work of H. Tristram Engelhardt, Jr. This problem is explored below.

9. Engelhardt's "Principle of Permission" specifically attempts to avoid this problem by taking respect for autonomy not as a substantive moral position, but rather as a basic, contentless requirement for moral action (Engelhardt, 1996). The problem with this position is that it results in a dilemma: it either suggests that any wish expressed by an individual, no matter how extreme (so long as the individual does not actually claim to hold an incompatible view such as "both X and not X"), ought to be honored, or imports a substantive moral view by articulating the conditions under which consent is legitimate (see also Khushf, 2015, on this point). The latter case would fail as a merely procedural, contentless alternative to the necessity of making moral claims in conditions of uncertainty, because it would assume nonobjective values in articulating the conditions of legitimate exercise of autonomy. The former would require other moral agents interacting with that person (and whose lives may be affected in various ways by the patient's decision) to ignore simple, obvious, remediable problems with decision making such as the effects of prescription (or recreational) drugs, oxygen insufficiency, etc. This would externalize the moral cost of pluralism—in this case, being party to the easily preventable morbidity or mortality of a patient whom we might know or suspect would prefer us to make a value-based judgment on his behalf—to all other parties in the situation.

10. The essay was motivated in part by James' observation of students who became "well imbued with the logical spirit" and rejected faith claims as not philosophically "lawful" (despite the fact that these students were "personally all the time chock-full of some faith or other themselves"). The essay was also a response to an argument by William Clifford that "[i]t is wrong always, everywhere, and for every one, to believe anything upon insufficient evidence" (Clifford, quoted in James, 1912, §II).

11. Or for moral progress, for that matter, because what would be the grounds by which one could urge change within such a society? Any public acknowledgement that a society is not already built on certain and clear foundations risks beginning to erode faith in those foundations.

12. The reason they will lack foundations is that such choices can involve iterations of choices, and most moral theories do not present an accommodation for moral tie-breaking or interpretation within their scope. Moral choices involve interpretation, and not every interpretive eventuality can necessarily be articulated within the framework of a moral theory. Sooner or later in actual decisions, we step outside the boundaries of theory.

13. It is true that individuals convinced of the certainty of their moral foundations can confine themselves to their communities where, they hope, certainty can be maintained. But as a matter of fact, hardly anyone does, choosing instead to live, work, or at least pass through the realm of moral foreigners. Even within communities, individual judgments can depart from the party line—think for example of Catholics who support divorce or female ordination, or of the proliferating strains within single Protestant faiths, where individuals can leave one parish or church for another more sympathetic to their views. Engelhardt (1996) argues that such interactions should be governed by a Principle of Permission whereby the parties work out conditions of cooperation for themselves, but even here, value-based decisions must be made. For example, under what conditions is someone or some group an entity with whom one may negotiate? See my arguments related to this in (Rasmussen, 2015b).

14. A religious enthusiast might conclude that precisely because no pluralist or secular moral certainty can be obtained, every individual ought to adopt a religious or other absolutist value system (being careful to find the right one). I disagree with this position, but even if we were to adopt this provisionally, it does not acknowledge, first, that many others do not accept it and, second, that even among those who do, there can be times of doubt or questioning and particular judgments that may not be addressed by one's religious authority. These kinds of circumstances create the space for at least the possibility of aid from others who do not share one's foundations (because one is unsure oneself of those foundations) in making moral decisions, and this raises the question of what counts as justification.

15. See Jerry Seinfeld's skit "night guy vs. morning guy," [On-line]. Available: https://www.youtube.com/watch?v=W-Cz-LK16g4 (accessed June 2, 2016).

16. Of course, given the realities of clinical ethics consultations, there is the very real possibility that the "self" under consideration will in fact not experience the consequences of the decision being made, because he will be dead. Even so, we can acknowledge that consequences will likely be experienced by those surrounding the decision who were also involved in the choice.

17. I am ignoring a couple of possible, but less important justifications for clinical ethics consultation. For example, we might argue that since many patients find consultants helpful, that is sufficient justification for involving them (Gilmer et al., 2005). Or, we might argue that they are justified in light of the money their consultations save (Heilicser, Meltzer, and Siegler, 2000; Schneiderman et al., 2003; Gilmer et al., 2005).

18. Incidentally, this aspect of clinical ethics consultation may explain variation in recommendations of clinical ethics consultants to a given vignette (Fox, Daskal, and Stocking, 2007; Fox and Stocking, 1993). Because what is required in case consultations is a dynamic process of investigating and confirming information, stakeholder input, etc., the static process of responding to a case vignette is ill-suited to discover a consensus that might exist when consultants are able to probe for more and better information. Good decision-making in clinical ethics consultations requires asking questions.

19. Tapper et al.'s (2010) study of consultations at one institution amply supports this claim. Although the vast majority of consults were "brief," they still took considerable amounts of time, in the range of 2-3 hours (see Table 5). "Full" consultations often required closer to 2,000 or 3,000 hours of work.

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