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Jamie Carlin Watson
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Moral Expertise

New Essays from Theoretical and Clinical Bioethics

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Introduction

Jamie Carlin Watson and Laura K. Guidry-Grimes

1.1 The Problem of Moral Expertise

When an attending physician needs specialized assistance with a patient's end-stage renal disease, she requests a consult from a nephrologist—an expert on kidneys. When a fellow has a question about the effects of depression on a patient's decisional capacity, she calls for a psychiatric consult—an expert on mental conditions. And so, if a physician needs information about the moral implications of a treatment plan, why shouldn't she turn to someone competent in the subject of ethics—a moral expert?[1] While the former requests are regarded as prudent and commendable, the latter strikes many as scandalous.[2] And yet the role of ethicists in professional decision-making in fields such as business, research, and medicine is steadily increasing.

Moral concerns about how patients and research participants are treated by medical staff and researchers led to the subfield of bioethics. In the United States, accreditation by The Joint Commission requires hospitals to have a mechanism for

[1] Some scholars attempt to maintain a distinction between morality and ethics, but here we follow the majority of academic philosophers in using them interchangeably to refer to the study of the related concepts of good, bad, right, wrong, permissible, impermissible, and obligatory.

[2] Richard Zaner expresses the timidity many ethicists feel embarking upon the task of ethics consulting: "[M]any of us felt acutely out of place and recoiled in shock and dismay" (1988: 5). Giles Scofield excoriates the notion, arguing that "medical ethics consultants neither know nor agree on what they do for a living, much less what one needs to know and what skills one needs to do whatever it is they do for a living (2008: 96). And Julia Driver notes that this sentiment extends fairly widely, since most of us are even more willing to accept aesthetics experts than ethics experts, "displayed by a willingness to be guided by the advice of art critics as to what movie we ought to see, and what art exhibit is the most worthwhile" (2006: 619).

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addressing ethical concerns.[3] In most cases, this takes the form of an ethics committee, but in some cases also includes an ethics consultation service. Motivated independently of professional regulation, many large hospitals now offer ethics consultation services.[4] A 2007 report shows over 300 clinical ethics mechanisms in German hospitals.[5] And in 2011, the UK Clinical Ethics Network (now, UKCEN) website included over 100 UK hospitals claiming to have clinical ethics mechanisms.[6]

What's more, a large number of active and thoughtful scholars—working with or through organizations like the American Society for Bioethics and Humanities, the Association for Practical and Professional Ethics, and UKCEN—have developed and tested strategies for enhancing practical moral decision-making in clinical contexts, putatively improving the quality of patient care and reducing the emotional and psychological effects of morally charged situations.

There remains, however, a raw uneasiness with the idea that ethicists might contribute something meaningful to clinical decision-making. This uneasiness is not new. The idea that one can justifiably tell others what they morally ought to do has been controversial at least since the fifth century BCE, when Heraclitus reportedly said, "Of all those whose accounts I've listened to, none gets to the point of recognizing that which is wise…."[7] In the early 300 s BCE, Plato tells us that Socrates attempted to convince Meno and Protagoras that virtue cannot be taught.[8] In contrast, Plato's pupil Aristotle argued that *phronesis* (practical wisdom, which includes wisdom regarding virtue) not only can be attained, but that a dialectical process might allow us to identify and trust those who have attained it.[9] These discussions have become more sophisticated over the succeeding centuries, informed by ever more nuanced debates over moral theory,[10] yet it remains contentious whether anyone can speak authoritatively on moral matters.

Of course, apart from the philosophical debates, we all share a deep sense that, at least in some instances, we *know*[11] the morally preferable thing to do, from decisions about lying to loved ones to voting for public policies. Further, assuming there is some moral reality, we cannot avoid making decisions that have moral implications:

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[3] Joint Commission (1992). The Joint Commission is the independent, not-for-profit accrediting body for hospitals in the United States (formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)).

[4] Fox et al. (2007). Fox, et al. estimate that every hospital over 400 beds has an ethics consultation service, but there are concerns with their sampling methods, and there is disagreement over how broadly they construe "consultation service."

[5] Döries and Hespe-Jungesblut (2007).

[6] UK Clinical Ethics Network (2011).

[7] Heraclitus: *Fragments*, Fr. 108. T. M. Robinson, trans.

[8] Plato, *Meno* (1997a), *Protagoras* (1997b).

[9] See Khan (2005: 49–51).

[10] For more on the history of this debate, see the first seven chapters of Rasmussen (2005), which include discussions of Socrates, Aristotle, David Hume, J. S. Mill, Josiah Royce, John Dewey, and G. E. Moore.

[11] Or that we at least have *well-justified beliefs* about the morally preferable thing to do.

we *will* make decisions about lying to loved ones and public policies. And in medical contexts, such decisions have higher moral stakes, greater complexity, and more urgency (see Shuster 2014). Unless there are no objective moral truths, it seems at least plausible that some of our beliefs about morality are justified. For instance, it is generally uncontroversial that slavery is morally impermissible, that kindness towards animals and humans is morally good, and that parents have a moral obligation to feed their children. Setting aside the difficult theoretical debates on this topic, we will assume, for the sake of this volume, that there is an objective moral reality of some sort, and that, in some cases, we really do have justified beliefs (perhaps even knowledge) about what we ought morally to do.

But even if we can have justified moral beliefs about *our own* moral decisions, there is still a question of whether we could form such beliefs about others' decisions, and, of significance for this volume, whether we could *expertly* advise others regarding their moral decisions. The prominent—perhaps dominant—answer of philosophers has been *no*. The standard interpretation of Immanuel Kant is that moral authority can derive only from one's own will.[12] John Locke famously doubted whether we can learn much through testimony, writing, "we may as rationally hope to see with other [people's] Eyes, as to know by other [people's] Understandings."[13] In the twentieth century, A. J. Ayer argued that it is mistaken to look to philosophers for moral guidance.[14] Gilbert Ryle argued that no one can be a moral expert because there is nothing in morality for anyone to be an expert about.[15] C. D. Broad argued that moral philosophers have no "special information" about ethics that is not available to everyone else, and so "it is no part of the professional business of moral philosophers to tell people what they ought or ought not to do."[16] And Bernard Williams says it is a *notorious* fact that there are no experts in ethics, singling out medical ethics as a prominently implausible attempt at developing them.[17]

This skepticism, combined with the growing number of ethicists serving in professional contexts, leads to an apparent conflict. If the very idea of someone's

[12] See Wolff (1970) and Zagzebski (2012). Some scholars, like Immanuel Kant and J. S. Mill, can be interpreted as defending the idea that part of what makes your knowledge of morality *knowledge* (in a strong sense) is that it is a result of reflecting on your own decision-making process. In other words, it is a function of your autonomy as a rational agent. Mill writes, "If a person possesses any tolerable amount of common sense and experience, his own mode of laying out his existence is the best, not because it is the best in itself, but because it is his own mode" (2002: 69). Of course, even Kant doesn't rule out the possibility of checking your reasoning against the informed opinion of others. See Zagzebski (2012: 23–26) for an excellent discussion of how Kant regards testimony in his *Anthropology*

[13] Locke (1979).

[14] Ayer (1954).

[15] Ryle (1958). However, see Arjo in this volume (Chap. 2) for a discussion of Ryle's account of knowledge.

[16] Broad (1952: 244).

[17] Williams criticizes the field of medical ethics in two places: "Who needs ethical knowledge?" (1993) and "Truth in Ethics" (1995).

speaking authoritatively in matters of moral decision-making is problematic, what goals might these scholars, committees, and consultants aim to achieve? Are they a sort of "ethics police," bringing abstract philosophical concepts to bear on the concrete realities of medical care? Are they conflict-mediators in disguise? Do they simply ensure compliance with professional codes and legal standards? Are any claims of ethics expertise legitimate? If so, who could claim it, and what would it imply for non-experts? Should non-experts defer to these experts, as they would to their accountants and physicians?

There are, to be sure, an increasing number of educational degrees, programs, fellowships, conferences, and scholarly works aimed at helping ethics committee members and consultants develop the ability to recognize and respond to difficult moral situations. Such initiatives suggest the possibility of establishing and conferring credentials on participants, similar to other professional organizations. But given classic concerns about having moral authority, the question remains as to what these initiatives are accomplishing: What sort of expertise are they credentialing?

In the first half of this collection, contributors explore theoretical debates over the possibility, nature, and implications of moral expertise in general. In the second half, contributors explore practical debates over purported moral expertise of clinical ethics consultants (CECs). This volume should appeal to moral philosophers, academic bioethicists, CECs, clinicians, hospital administrators, ethics committee members, and others who want to gain a deeper understanding of the potential scope of moral expertise in real-world contexts.

1.2 The Role of Clinical Ethicists

There is a rough consensus among scholars of clinical ethics consultation that the goal of ethics committees and consultants is to help clinical staff, patients, and families navigate a variety of moral and non-moral features of difficult situations so they can make better moral decisions.[18] Non-moral features include professional responsibilities and constraints, political and cultural expectations, institutional policies, legal responsibilities and constraints, and the cultural-historical backdrop of medical practice.[19] Moral features include respect for (and threats to) patients' well-being and autonomous interests, which include risks regarding pain and death, respect for an aspect of identity (such as gender, sexuality, race, religion), marginal-

[18] Puma et al. (1995); ASBH (1998) and (2011); Aulisio (2003); Jonsen et al. (2010); Dubler and Liebman (2011); Hester and Schonfeld (2012). See Scofield (2008) for a critique of these stated goals.

[19] To be sure, each of these has moral implications. The point is to simply highlight that neither laws nor institutional policies are, in themselves, moral statements, even if motivated by moral concerns with moral implications for care. For instance, a federal law requiring that all new employees have the legal right to work in the country is not itself a moral requirement. Similarly, an institutional policy that all team members wash their hands has clear moral implications, but not every instance in which that policy is violated is a moral infraction.

ization, and unjust treatment. Threats to such interests also include patients' *perception* of medical treatment. In some cases, patients do not recognize threats that may ultimately compromise their moral interests. In other cases, they perceive threats to their well-being or autonomy where there are none. And clinicians are not immune from these blind spots; their perceptions can be underinformed, unnuanced, or simply mistaken. This fallibility suggests that even when a clinician perceives that a patient's expressed preference is "irrational,"[20] he should take that preference seriously in decisions regarding patient care.

Consider two common moral situations clinicians face:

- A 45-year-old patient has been refusing above-the-knee amputation for a gangrenous leg, even though the surgery would likely extend his life. The infection is now imminently threatening his life, and his capacity has become unclear with his condition worsening. The patient's wife says the patient is not in his right mind and really wants to live, and she begs the surgical fellow to perform the amputation against the patient's wishes. The patient's son says the patient has very strong opposition to being "crippled" or "disabled" and would prefer to "die with his boots on." The nurses on the unit are expressing increasing discomfort with letting a patient die from a treatable illness. The surgical fellow cannot get in touch with the attending physician and calls for an ethics consultation.
- A 60-year-old patient with unclear capacity and no surrogate decision-maker requests to stop kidney dialysis, which will result in her deterioration and eventual death on this admission to the hospital. The dialysis is expected to keep her relatively stable for years to come, and she could probably be discharged back to her nursing home. The attending physician believes that requesting to stop a life-saving treatment is tantamount to requesting suicide, so the physician refuses to accept the patient's request. The physician treats the patient's increasing agitation with Haldol before the next dialysis session, but the patient still physically resists. A nurse working with the patient anonymously calls for an ethics consultation.

Other controversial cases include questions regarding "dignified death," maternal-fetal conflict, "medical futility," the appropriateness of unilateral DNR, and requests for posthumous ovum or sperm retrieval. While some of these moral complexities will be rare, moral red flags and problems arise on a daily basis in a hospital. As emphasized by Mark Aulisio, healthcare settings are increasingly ripe for ethics consultation: "Even as the complexity and number of choices facing patients, families, and providers multiplies, the contemporary health care environment is increasingly less conducive to good decision making."[21] Standard care in a hospital frequently involves many specialties and sub-specialties, imperfect handoff among physicians, the rise of managed care with less time spent per patient, length of stay pressures, and economic considerations.[22] From all of this, it is evi-

[20] See MacIntyre (1988) for the influence of different accounts of rationality on decision-making.

[21] Aulisio (2003: 5)

[22] Many of the items on this list come from Aulisio (ibid.).

dent that ethical difficulties will abound in any healthcare setting. If a hospital reports having relatively few ethics consults (or none), this is not evidence that ethical issues are few and far between; rather, this is evidence that the health care professionals do not have a robust ethics consult service, do not know of the existence of the service, and/or do not trust in the service.

What might ethicists contribute to these complex ethical decisions? Is there a recognized and widely accepted subject matter the ethicist can apply to such decisions, as an internist or psychiatrist might in their fields? Should ethics consultants offer moral advice on how to resolve such conflicts, or should they only clarify putatively competing values? Should committees make recommendations to medical teams about what is preferable (as, say, a nephrologist or oncologist might), or should they only talk through the morally salient considerations, "supporting a critical inquiry of moral convictions and moral questions"?[23] And if they do make recommendations, to what degree, if any, are those morally binding on the participants' decisions?

The answers to these questions depend on the nature and scope of moral expertise, whether there are any moral experts, and if there are, what their expertise implies for the recipients of their testimony. These are the topics addressed by the contributors to this collection, and the chapters that follow are relevant not only for potential ethics consultants, but for clinicians who engage with ethics committees and consult services, ethics committee members, policy committee members, board members, and academic bioethicists.

In the remainder of this introduction, we sketch the major outlines of contemporary debates on these topics. We begin with some basic concepts and distinctions common to the debate, namely: different ways of conceiving expertise, different conceptions of moral expertise, the distinction between political and epistemic authority, and the distinction between situational authority and expert authority. We then review debates over what moral experts could tell us if there were any, and we discuss some important developments since Lisa Rasmussen's important 2005 collection *Ethics Expertise: History, Contemporary Perspectives, and Applications*. We close this introduction with an outline of the contributions to this volume.

1.3 Concepts and Distinctions

1.3.1 What Is Expertise?

Whether it is plausible to be or to justifiably believe someone is a moral expert depends heavily on what it means to be any sort of expert. Unfortunately, the increasingly rich literature on expertise is often neglected in discussions of moral

[23] Stolper et al. (2010: 151).

expertise.[24] A brief review of two prominent accounts of expertise highlights the importance of this literature for moral expertise.

The most prominent account of expertise is veritism, from the Latin *veritas*, which means "truth." According to veritists about expertise,[25] experts have authority because their beliefs are "truth-tracking," that is, they have a "substantial fund" of reliably true beliefs in a subject matter (see Goldman 2001). Some veritists require that experts have more reliably true beliefs *than false in a subject matter* (Goldman 2001). Others argue, more modestly, that experts have more reliably true beliefs *than others in their epistemic*[26] *community* (Fricker 2006; Coady 2012).

The term "reliably" is important because it indicates that experts do not have their true beliefs accidentally (because you happened to overhear your physician mother talking as you grew up) or through some arbitrary means (memorizing the claims in a medical textbook). Experts have more true beliefs because they gained access to the relevant content by a means that allowed them to understand and apply evidence relevant to those claims, and they used those claims in a way that developed competence.

A moral expert, on this account, would be someone who has substantially more reliably true moral beliefs than others. This raises important questions for scholarship on moral expertise: Can someone have more reliably true moral beliefs than someone else? How might we know? And are there true and false moral beliefs, or is morality substantially different from other types of subject matter? The implication is that which account of expertise we presuppose affects how we evaluate the possibility and plausibility of moral expertise.

An alternative prominent account of expertise was developed by Hubert Dreyfus and Stuart (1980; 1986). This account focuses on expertise as skill acquisition rather than merely knowledge acquisition: someone is an expert in a subject matter if they can *do* something competently in that subject matter, even if the doing requires a substantial degree of knowledge. The Dreyfuses view expertise as the upper end of a competence continuum, starting with novice, progressing through advanced beginner, competence, and proficiency, and culminating in three categories that allow one to practice and eventually teach: expertise, mastery, and practical wisdom.

The benefits of this account highlight the roles of teaching and culture in the acquisition of expertise. Different teachers have different styles of practice, and while copying a style may be sufficient for basic expertise, a master recognizes that she must adapt her teacher's style into her own. Further, the language, communica-

[24] Exceptions include Hopkins (2007) and Priaulx, et al. (2014).

[25] Those who defend some version of veritism include Alvin Goldman (2001), who coined the term, Elizabeth Fricker (2006), Jimmy Alfonso Licon (2012), and David Coady (2012).

[26] The term "epistemic" refers to concepts associated with knowledge or justified belief. A person's "epistemic community" is the group of people closest to the person in terms of what they are interested in knowing, how questions are framed about that subject, and the relevant evidence and strategies for answering those questions. For instance, the international community of scientists would be members of a chemist's epistemic community.

tion techniques, attitudes toward our subject matters, and even the structure of a profession are determined in large part by that field's culture. As one masters the content of a subject along with that field's culture, they come to embody the practical wisdom associated with that field. All of this suggests that a large part of being an expert is *tacit* rather than *explicit*, that is, it is less about acquiring and applying knowledge claims and more about being an active member of a field.

A recent prominent version of performative expertise was developed by Harry Collins and Robert Evans (2007). Like the Dreyfuses, Collins and Evans view expertise on a continuum from low levels of expertise to high levels. They begin with *ubiquitous expertise*, low-level skills that everyone can master (such as native language use) and proceed to higher-level skills of *interactional expertise*, which allows an expert to engage with a subject matter on its own terms (such as a science writer for the *New York Times*). If one pursues specialized experience in a discipline, one may be able to achieve the highest level of competence, *contributory expertise*, which is the competence to participate in a subject matter as a contributor (e.g., a respected astrophysicist). Also like the Dreyfuses, they focus on tacit knowledge as the primary feature of expertise.

Unlike the Dreyfuses, Collins and Evans ground their continuum in a number of social science experiments, and based on that research, they develop a rich set of conceptual distinctions that help explain many of our intuitions about expert authority. For example, they argue that interactional experts rely heavily on contributory experts, that contributory expertise entails interactional expertise, and that both require one to develop the social capacities they call "interactive ability" and "reflective ability."

Crucial to their account is a set of meta-criteria that help explain how one becomes an expert and also how non-experts can recognize experts. As you might expect, these criteria include the putative expert's credentials, experience, and track record. Interestingly, these meta-criteria also admit of meta-expertises, which are the continuum of skills necessary for using these criteria well. These distinctions have important implications for evaluating the role and authority of clinical ethicists, especially considering the recent debate over whether anyone could be credentialed as a moral expert (see Vogelstein in this volume).

We will not delve deeper into this account of expertise except to note that it was introduced into the discussion of moral expertise in 2014 by Nicky Priaulx, Martin Weinel, and Anthony Wrigley. They argue that the Collins/Evans account entails that moral expertise is not only possible, but plausible. If we all have basic moral competence, we share what the Collins/Evans model deems ubiquitous moral expertise. And it seems that those who have studied moral philosophy may achieve interactional and contributory expertise in the subject matter of ethics. Further, even those who haven't studies moral philosophy may, nevertheless, achieve specialized expertise in "robust moral judgment."

Unfortunately, Priaulx, et al. stop at robust moral judgment and do not discuss whether this judgment is restricted to personal moral decisions or whether it could be extended to helping others make better moral decisions. While it seems uncontroversial that a moral philosopher could achieve interactional moral expertise in the

academic study of ethics, it is less clear whether someone could achieve it in helping others. Nevertheless, Priaulx, et al. have demonstrated how the concept of expertise can enrich debates over moral expertise.

While veritism and performative expertise are the most widely discussed accounts of expertise, there are others that may be helpful in discussions of moral expertise (see Hopkins 2007, Watson 2018, and Quast 2018). This growing literature on general expertise has remained largely disconnected from discussions of moral expertise. Moral expertise may be more or less plausible depending on which account of expertise is most plausible. Further, the sorts of skills and knowledge one may need to become a moral expert may be different depending on which account of expertise is plausible.

1.3.2 What Kind of Moral Expertise?

Moral expertise refers to several distinct concepts. In order to restrict our focus to the moral expertise relevant to the clinical context, it will be helpful to compare and contrast these notions. Perhaps the most common type of moral expertise is that of the scholar who studies and teaches moral philosophy. It is uncontroversial to regard someone who has achieved advanced degrees in moral philosophy and actively participates in academic discussions through publication and conferences as an expert in moral philosophy. Such a person tends to have the ability to explain the details and implications of a variety of metaethical and normative moral theories, detail contemporary controversies surrounding those theories, and help others understand the significance of those debates. We will call this sort of expertise *academic moral expertise*.

Yet, academic moral experts might be incapable of expertly advising others about what morally they ought to do (see Butkus in this volume). Although many academic moral experts teach applied or practical ethics, they often abstract from the complexities of scenarios in which some of those decisions must be made.[27] For example, in discussions of abortion, moral philosophers will often talk about the nature of personhood, individual rights, and types of moral standing. All of these questions are relevant to practical moral decision about abortion, but they are certainly not the only relevant features in any actual clinical case. Further, in academic discussions, philosophers can assume certain variables are fixed in order to test intuitions and isolate specific moral concerns.

[27] Burch (1974) puts this point eloquently: "In the typical moral problem, the ethically relevant features are tricky to specify and extremely difficult to weigh with respect to one another. Moreover, there is no given short-list of possible actions to be decided upon; instead there looms before the person deciding what do to an open field of infinitely diverse actions, shading into one another in countless, different ways. To be or not to be is hardly ever the moral question, but rather when, where, how, for whom, how much, and in what respect to be or not to be. A moral problem calls not for a mechanical response, but rather for a creative act" (655).

By contrast, in actual cases where abortion is considered, decision-makers face questions of decisional capacity, religious commitments, legal constraints, relational autonomy in a variety of cultural contexts, actual or potential risks, insurance limitations, and a wide variety of medical contingencies. In some cases, answers to crucial questions are not available to decision-makers. In other cases, crucial answers are disregarded by decision-makers as irrelevant. Further, clinical ethicists do not have the luxury of time and distance. And yet, in all these cases, decisions must be made.

None of these variables can be suspended or held fixed in the clinic as they can in the classroom. Even when certain stakeholders (such as physicians, patients, or family members) hold beliefs that strike us as irrational or contentious, no stakeholder's perspective is irrelevant. The student and the CEC therefore stand in a different relationship to the ethical problem or conflict. And so, as important as academic moral expertise is, it is not obvious that it is sufficient for helping clinicians, patients, and families make better medical decisions. At least some clinical knowledge and experience making decisions in complex, non-hypothetical cases are necessary.

A second type of moral expertise is the competence to reliably make good moral decisions for oneself. That is, one might be a moral expert if one were competent at living a morally good life. Describing this sort of competence, Robert Burch (1974) writes that ethicists are:

> … good at discerning what is right and wrong, and in doing something about it. … [They have][28] the capacity of discerning details and the knack of penetrating beneath the surface of convention and idle talk. [They have] insight into the ways one can twist or blunt moral issues, and [they have] competence in stiffening [their] wills so that [they do] not always take the easy way out (652).

We will call the ability to act as a morally good person, regularly or perhaps more often than not, *performative moral expertise*.[29] This type of expertise is more controversial. How might someone achieve it? How might they demonstrate it? For a contemporary defense of moral expertise as performative, see Hulsey and Hampson (2014).

Again, however, even if one could achieve performative moral expertise, this is not obviously the sort of expertise one would need to serve as an ethics consultant. One may perform well as a moral agent without being able to help others achieve that competence. Many of us have had classes with exceptional scholars who could not communicate clearly or effectively regarding their subject. The question of whether one can expertly navigate one's own moral path is independent of whether she can help others expertly navigate theirs.

This is not to say that the sort of moral experts we are interested in should (or would) have no ability to make good moral decisions for themselves. In fact, it

[28] The brackets in this paragraph replace masculine pronouns with plural pronouns.

[29] There is no widespread consensus on this terminology. Cheryl Noble (1982) might call this "moral wisdom," and Bruce Weinstein (1994) calls this "expertise in living a good life."

would be difficult to trust someone who did not act at least in the spirit of the advice they give (see Cholbi 2007 for an argument along these lines).[30] The point is simply that, the competence to advise someone in a type of decision-making does not entail that one regularly incorporates such advice into her own decision-making.[31]

And, of course, even if one were motivated to do so, one might not have achieved mastery in this for any number of reasons, including weakness of will, lack of opportunity to practice making such decisions for themselves, or simply being too close to some decisions to view them objectively. This latter concern is precisely why academics and researchers value processes like peer review. Plausibly, one aspect of becoming (and continuing to be) an expert involves regularly putting oneself in a position to receive feedback from other experts. But one can explain the problem of, say, confirmation bias, along with strategies for avoiding it, even if one does not avail himself of those strategies.

The type of expertise in which we are interested, then, is the competence to help others make better moral decisions. As noted, this likely entails some degree of academic and performative moral expertise, but it is conceptually distinct, consisting primarily in the authority to speak (in a sense yet to be explicated) on moral matters within the scope of a certain subject matter. This type of expert understands both sophisticated moral philosophy and the concrete complexities of a particular subject matter, whether business, or research, or medicine (and in some cases, subfields, like end-of-life care and pediatrics).

In medicine, these complexities might include the risks to a patient who will not likely comply with the post-op care for a medically indicated surgery, the risks associated with discharging a patient to an unstable environment, the undue influence of an overbearing family member, the paternalistic stance of a physician toward any patient with a psychiatric history, or the seemingly irrational fears of a patient. This type of moral expert can draw informed distinctions between the moral and non-moral features of a case, work with clinicians and families to weigh the conflicting and complex features against one another (recognizing that how much weight some considerations have depends on how much they give it), and form a moral judgment about a morally preferable plan of care. This moral judgment would then need to be conveyed in a manner and language useful to the clinicians, patients, or families who receive that judgment. To make her advice useful, the moral expert would need skills for translating rich moral notions into the practical realities of the context at

[30] Julia Driver offers a humorous example: "Satan could well be an example of a being with superior moral knowledge, but it would be unwise to defer to Satan's judgment on what to do. I might be confident in his ability to know, but not confident in his accurate transmission of that knowledge, because I view him to be deceitful" (2006: 630).

[31] Dale Miller (2005) notes that some, like J.S. Mill, hold that there is no "intrinsic connection between moral beliefs/knowledge and moral motivation" (a view known as moral externalism), which means that knowing the right thing to do does not entail that one will feel any motivation to act on that belief. "This implies that while those with greater moral expertise might be able to lay claim to greater moral knowledge, … it would be a mistake to assume that they are automatically more virtuous…than anyone else" (83).

hand. We will call this competence to speak authoritatively about moral matters, *practical moral expertise*.

To be sure, practical moral expertise may not be possible. Some, for instance, argue that there is not a single moral judgment that answers a moral question, but instead, only opportunities to learn more about others' meanings and perspectives.[32] But even if it is possible, it might be extremely rare. And even if it is not rare, clinical ethics consultants may not need *this sort* of expertise to contribute to high quality patient care (see Rasmussen 2011). Iltis and Sheehan (2016) argue that the field would benefit from dropping the term altogether. As will be illuminated in the chapters that follow, clinical ethics consultants (CECs) may be viewed as skilled professionals who can offer important contributions even if they are not, or should not be regarded as, practical moral experts (see Fiester in this volume). Nevertheless, if some CECs are plausibly moral experts, this has important social and professional implications for bioethics, clinical education, and a variety of clinical relationships.

1.3.3 Political vs. Epistemic Authority

Calling someone an expert has a number of social connotations. Someone who is an expert has *authority* to speak on certain matters. And the concept of authority is associated with everything from the right to coerce (as in cases of political or legal authority) to religious and civil practices of including and excluding ("I baptize you…"; "By the power vested in me, I pronounce you…"), to certain representative capacities (as in the case of ambassadors or executors). These examples also highlight that the notions of "authority" and "rights" are closely related: the *right* to do something, the *right* speak about a subject. These latter are so closely associated, in fact, that some philosophers have conflated them.

Hannah Arendt (1961) associated the notion of authority exclusively with the political relationship between leaders and citizens, in particular, the power to command. If the relationship holds, citizens obey a leader's commands without needing an explanation (the leader has authority). If a political figure must exert coercion to enforce a command, then authority has failed (the leader has no authority to command). If a political figure uses reason and citizens follow because of the reasons given, authority is not invoked in the command; the citizens follow because of what they understand, not because the leader has commanded (in this case, she says, "authority is in abeyance").

Robert Paul Wolff (1970) agrees with Arendt that authority must be distinguished from the ability to coerce (power) and persuasive argument, and concludes that authority "resides in persons; they possess it—if they do at all—by virtue of what

[32] Widdershoven and Molewijk (2010).

they are and not by virtue of what they command."[33] But Wolff then argues that authority—in this sense—is inconsistent with *autonomy*, which he says is the moral obligation of each of us to take responsibility for our own actions. The concept of authority entails, according to Wolff, that someone cannot accept or follow the testimony of any putative expert on the basis of their testimony alone without also relinquishing her autonomy: "by refusing to engage in moral deliberation, by accepting as final the commands of the others, he forfeits his autonomy."

Yet, while this might be an apt way to describe authority in certain political structures, it is not obviously what is implied when an expert speaks about her special subject matter, and to assume without argument that the implications of political authority apply *mutatis mutandis* to non-political conceptions is controversial, at best.

When, say, a geneticist, speaks about the relationship between alleles and gametes, there is a sense in which others *should* take her seriously. We *ought* to accept her testimony (at least *prima facie*); she has authority in her field. We might even say she has a *right to be listened to*. But the sense of "right" here is weaker than we find in political contexts. No one would worry that in accepting an expert's testimony they are forfeiting their autonomy or giving up their independence of judgment. We wouldn't call someone *immoral* who refused to accept a scientist's or say that they violated that scientist's rights. We might, of course, say such a person is *irrational*. But whether it is rational to listen to someone is distinct from whether they have a strong or political right to be heard.

Let us assume, then, that expert authority, at minimum, places a default *rational* demand on the recipients of that expert's testimony to accept that testimony, to defer one's judgment to the expert's. This type of authority is known as *epistemic authority*. To avoid confusion, then, we will not say an expert *has a right to be listened to*, but instead that an expert *should be taken seriously*, leaving the implications of "seriously" open to interpretation. The reason to leave it open at this stage is that there are wide-ranging disagreements about what epistemic expertise implies normatively, one of which we will briefly review briefly in the remainder of this subsection. But even on a fairly strong view of what it means to defer one's judgment, epistemic authority is distinct from political authority.

[33] 1970: 6. George Agich (1995: 274) calls this the "command-obedience" model of authority, which is grounded in political structures. He contrasts this with "social role authority," according to which someone accepts a person's testimony based on a set of complex, informal social relationships. For example, "a teacher does not order students, except when he behaves as a disciplinarian and then does so as a school official in charge of conduct. Teaching as such involves complex processes of communication that bind student and teacher into an authority relationship where teaching and learning occur. A scientist interacting with peers might rightly take their word on a particular scientific point over that of a layman. Such trust is based not simply on other scientists' power or position, though that might to some degree contribute to the initial acceptance, but also on their common commitment to methods of work and modes of demonstration" (276). In subsequent paragraphs, we call social role authority "epistemic authority."

1.3.4 Taking Experts Seriously

In considering how one should receive authoritative testimony, one might take a strong view, that one should defer completely to an expert, irrespective of any other reasons one might have. Alternatively, one might take a weak view, that an expert's testimony is one piece of evidence among several—albeit a rather weighty piece—that must be evaluated in light of one another.

Linda Zagzebski (2012) defends a version of the strong view: the obligation to take an epistemic authority seriously entails that one accepts the authority's testimony about a subject *in lieu of any other reasons* one might have about that claim.[34] According to Zagzebski, an expert's authority "preempts" or "replaces my other reasons relevant to believing *p* and is not simply added to them."[35] The strongest case for this view appeals to empirical evidence that people who defer to experts do better and have more true beliefs than people who do not.[36]

Thus, in listening to an expert, one is more likely to form a true belief than if he tried to evaluate the reasons for that belief himself, and the expert's judgment would most likely stand up to his own efforts to evaluate those reasons (in other words, he would still regard the expert as reliable after what Zagzebski calls "conscientious reflection").[37] If this right, then we couldn't do better than listen to authorities when they declaim on a subject. And if we couldn't do better, we have a normative reason to defer to their judgments, irrespective of our other reasons.

In saying that an authority's testimony replaces or preempts one's reasons, Zagzebski does not mean that one ignores the other reasons she may have, nor does she mean that one actively decides to let an authority's testimony override her other reasons. She means simply that an authority's testimony constitutes a sufficient and overriding reason to believe that testimony.

Jennifer Lackey (2018) identifies a number of problems for this strong view of epistemic authority, and we will briefly highlight two. One problem, Lackey argues, is that Zagzebski's account "*fails to provide the resources for rationally rejecting an authority's testimony when what is offered is obviously false or otherwise outrageous*."[38] Experts are not only fallible; they sometimes say patently false things. Lackey gives the example of a pastor who may be highly regarded as a moral

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[34] Zagzebski draws heavily from Joseph Raz's (1986) account of authority, but for simplicity we will focus on Zagzebski here.

[35] Zagzebski, 107.

[36] In a suggestive study that Zagzebski cites by Mlodinow (2008), when animals discern that one choice is better a majority of the time, they choose that option every time. And thus, they choose the better choice most of the time; they are outcome-maximizers. Humans, on the other hand, are probability-matchers. If a choice is better about 75% of the time, humans will choose that option about 75% of the time, making it very likely that they will almost always choose the better option less than 75% of the time. (Zagzebski, 2012: 115)

[37] 110–111. By "conscientious reflection" Zagzebski means, "[u]sing our faculties to the best of our ability in order to get the truth" (2012: 48).

[38] (2018: 234).

expert but nevertheless makes a claim that women are morally inferior to men. If you are screening off other reasons, you should accept the pastor's testimony without question. And yet, even if you weren't a moral expert, you would likely have substantial reasons to challenge the claim.

A related concern Lackey raises is that "*it is unclear how the testimony of an authority can even strike one as clearly false or outrageous, given that all of one's other relevant evidence has been normatively screened off.*"[39] To be sure, one can experience a certain amount of outrage at a claim; Zagzebski's account doesn't make claims on our psychological states. Nevertheless, if you have normative reasons to set aside all other evidence, then you have normative reasons to dismiss your outrage as misplaced or misguided. But if this is right, how strongly should we trust the initial evidence we used to adopt the expert in the first place? And to what evidence would we appeal if two experts disagreed?

In contrast to the strong view, Lackey offers a weak version of expertise that she calls the "expert-as-advisor" view.[40] Lackey argues that it is far more plausible to view experts as advisors rather than authorities in Zagzebski's strong sense. Unlike authorities, advisors offer guidance, that is, their testimony counts as evidence for believing something. Lackey says that an expert witness at a trial is a paradigmatic example of an expert-as-advisor:

> No one would tell the jurors that the testimony of a given expert is authoritative or provides preemptive reasons for belief. Indeed, jurors themselves would be superfluous in many ways if experts functioned authoritatively. Instead, competing expert testimony is often presented from both sides—the prosecution and the defense—with jurors needing to evaluate the full body of evidence in reaching a verdict. The experts here are, then, advising the jurors rather than dictating to them what they ought to believe.[41]

To keep our terminology consistent, we regard this type of expert competence as a type of authority, but a type weaker than that advocated by Zagzebski. This weaker, advisory view of epistemic authority takes seriously the fact that experts are not only fallible, but that they can make audaciously false claims. Further, it takes seriously the fact that experts disagree over claims in their own fields, even fields as highly revered as medicine and physics. And it takes seriously that the relevance of expertise is often contingent on a number of contextual and decisional factors, some of which might not be available to the expert. She even names CECs explicitly as a case of expert advising:

> An ethics consultant serving at a hospital will be effective largely by helping doctors, patients, and their families navigate through difficult medical decisions. Sure, her reliably offering true testimony is important, but equally important are her abilities to clearly explain the terrain, to listen attentively and receptively to the concerns and values of those around her, and to answer questions in a thoughtful and constructive way.[42]

[39] Ibid., p. 235, italics hers.

[40] Ibid., pp. 238ff.

[41] Ibid., p. 239.

[42] Ibid.

By maintaining that expert testimony is one source of evidence among many, according to Lackey, we have far more opportunities for forming and enhancing beliefs in a subject. "We can evaluate the arguments proffered on behalf of a particular view, we can assess how able the expert in question is at enhancing our understanding of the matter, we can determine how effective the expert is at being an advisor, and so on."[43]

Although Lackey's view has intuitive force, it does not undermine Zagzebski's empirical argument that we would do better, overall, if we simply deferred to experts. The question, then, would be whether CECs could exemplify this stronger type of authority. The debate over strong and weak epistemic authority is more complex than we can pursue here. But this brief segment highlights its relevance for moral expertise. If couched strongly, moral expertise is less plausible and likely rare. If couched weakly, moral expertise is more plausible but perhaps more difficult to identify in training and practice.

1.3.5 Situational Authority vs. Expert Authority

A related and no less crucial distinction is between the authority to speak about a particular claim in a particular context, which we call *situational epistemic authority*, and *expert epistemic authority*, which is the epistemic authority to speak about a range of claims in a subject matter. One might have epistemic authority in some cases without being an expert and vice versa. For example, if you don't know what time it is and you ask someone with a watch, you have good reasons to trust their testimony regarding the time even if that person is not an expert on watches or the concept of time. And the person with the watch is in a better position to justifiably believe what time it is than you are[44] even if *you are* an expert on time or watches.

This phenomenon is explained by a person's access to evidence relevant for believing a claim. This access is called *epistemic positioning*.[45] An epistemic position refers to the relationship someone has to evidence. If we are on different sides of a brick wall, we have access to different visual evidence. If there is a dog on your side, then, other things being equal, you are in a better position to judge that there is a dog there. Many factors mitigate your position, such as how tired you are, whether you are on certain medications, whether I have reliable testimony that there is a dog there or a video feed of the dog. When such factors don't render our epistemic positions equal, that is, when one person is in a *better* epistemic position than another, that person has an *epistemic advantage* over the other person.

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[43] Ibid.

[44] Whether the person is in a better position to *know* the time (instead of merely *having a justified belief* about the time) is a more complicated question, leading to questions about the reliability of watches, the proper functioning of that person's watch, etc.

[45] See Elizabeth Fricker (2006).

In standard cases, experts are better positioned than non-experts with respect to evidence about claims in their subject matter. So, even though we have all had experience with time and watches, someone who is an expert about the concept of time has an epistemic advantage over the rest of us regarding the relation of time to space, the logic of temporal language, competing arguments regarding the structure of time, etc. This distinction becomes important in cases where non-experts have situational epistemic authority over experts with claims relevant to that expert's judgment. This can occur when some piece of information relevant for an expert's judgment is not directly accessible to her; it is contingent on someone else to provide it.

A prime example of a case where a non-expert has situational authority over an expert comes from the growing literature on *patient expertise*.[46] Patients, according to some, have insights into their medical conditions and personal values that physicians could not have, even in virtue of their medical expertise. And thus, patients have a certain degree of epistemic advantage over some claims regarding their treatment plans that physicians should take seriously.[47]

In the case of morality, too, we might recognize that sometimes people are in a better position than we are to know what is morally good, irrespective of whether they are experts. For example, parents tend to have situational epistemic authority over young children regarding basic moral heuristics—do not lie, cheat, steal, or cause pain—even if they cannot reliably discern when to do or not do those things in their complicated adult lives. Further, a minister or counselor might have some authoritative moral insight into a particular decision based on their experiences working with people who faced similar decisions. Further still, in circumstances where someone is emotionally overwhelmed or experiencing decisional fatigue, she might benefit from the judgment of someone else who is more distant from the situation and can therefore process all of the relevant considerations.

Expert authority, in contrast, refers to a more robust epistemic position. Experts do not simply have authority to speak about particular claims in particular contexts. Rather, they can speak authoritatively about a wide range of claims in a subject. They can answer questions about the terms, claims, and arguments in that subject, and they can use them to the satisfaction of others in that field. They can explain how those terms and claims came to be part of that subject, and they can apply those terms and claims to novel cases. To be sure, expertise comes in degrees, and advanced laypersons may engage with a subject in ways indistinguishable from new experts; nevertheless, the development of these traits is widely regarded as constituting one's epistemic expertise.

So, whereas most of us can add 237 to 458 without any trouble, an expert in mathematics can explain how to derive the rule that allows one to perform that func-

[46] See, for example Civan and Pratt (2007), Heldal and Tjora (2009), and Hartzler and Pratt (2011).

[47] It is controversial whether patient authority is plausibly regarded as "expertise." Given that any particular medical condition involves extensive subject matter outside the patient's competence, we have categorized this authority as situational with respect to evidence only the patient could have.

tion from Peano's axioms. Similarly, a practical moral expert, if there were one, could do more than simply state a moral aphorism, for example, that we should not violate a patient's autonomy interests. They could also explain why autonomy is morally valuable relative to other moral interests, identify when a decision would violate autonomy interests, and evaluate whether such a violation is nonetheless justified by competing interests.

1.3.6 Is Morality Unique?

A further relevant distinction is that between the content of ethics and the content of other subjects, such as mathematics or medicine. Could one have an expert-level grasp of the content of morality the way we assume one can have of calculus? As we saw in the discussion of authority, there is a long history of concern that morality is unique among subject matters. Whereas the empirical facts about nephrology or oncology are the special province of trained and certified people, we are all moral agents—we all have a sense of what is good and bad, right and wrong.

Immanuel Kant, for instance, argued that morality makes rational demands of us precisely because it is something to which we all have access. Kant argues that anyone who can reason can figure out what our moral obligations are in any given situation.[48] And if we all have equal access to it, it may seem unclear what rational demands one person could make of another person regarding her beliefs about that subject matter. This leads to the conclusion, as Giles Scofield puts it, that "either all are experts or none are" (1994: 420). We call this the *uniqueness problem* for moral expertise.

David Archard argues that universal access to moral content implies that *no one* is a moral expert. He argues as follows:

> A claim of moral expertise is a claim to command knowledge in respect of the making of normative judgments not commanded by others. But moral philosophers see themselves as required to construct moral theory on the foundations of common-sense morality. The latter is the set of moral maxims of which ordinary people have knowledge and of which they make use in their quotidian lives. These maxims comprise basic judgments of what is morally right and wrong. Thus by their own lights moral philosophers do not have command – in respect of the making of normative judgments – of knowledge lacked by nonphilosophers. Moral philosophers cannot, consistent with their own commitments to common-sense morality, claim moral expertise (123).

What Archard means by "common morality" is a technical matter (see Beachamp and Childress (2013) for a full analysis), but a rough distillation is "the minimal core set of ethical precepts that can be observed to be shared by all conscientious humans who seek to live their lives morally" (Archard, 124). And so, what ethicists study is precisely what all of us are already committed to. Archard takes this to

[48] His famous defense of this is in *Groundwork for the Metaphysics of Morals* (1785/1997).

imply they do not have a command of it that others do not, and thus—by his definition of expertise—no one is a moral expert.

Christopher Cowley argues, alternatively, that universal access implies that *everyone* is a moral expert, and thus, no one can effectively act as an expert: "*we are all ethical experts*, and so effectively none of us are [sic]" (2005: 276, emphasis his). Why might someone hold that universal expertise nullifies any social benefit of expertise? The presupposition seems to be that expert authority serves only non-experts. As Michael Cholbi puts it: "One's own expertise obviates the need to seek out other experts in the first place. Experts don't need the expertise of other experts" (2007: 324).

There are a number of important questions raised by these arguments. Is Archard's account of expertise plausible? Is it true that one's own expertise obviates the need for other experts? And are moral philosophers actually committed to respecting common morality, and, if so, whether this prevents them from being able to stand in a position of expertise relative to other moral agents?[49]

Another defense of the idea that morality is a distinct subject-matter—and thus that there can be no moral experts—is that, unlike other subjects, morality *can only be learned first-hand*, and, therefore, cannot be acquired through testimony. Charles Hendel (1958) puts it this way:

> [T]o allow of any possible role for authority in the moral life of [people] is to take away its properly ethical character, no matter whether the authority be divine or regal, because morality consists in actions of an individual's own authentic choice, choice in the light of [their] own knowledge, appraisal, and conviction, without any external inducements or sanctions (7).

The idea seems to be that, in order for a moral decision to be *authentic*, it cannot be supplemented with moral advice. One must understand and evaluate all the moral reasons relevant to a decision for oneself.

Christopher Cowley (2005) also offers a more recent version of this argument. He contends that, even if there were moral experts, moral decisions are personal in a way that other decisions are not. Even if you were to receive competent moral advice, "[you] cannot abdicate the decision to someone else in a way that would shift responsibility and blame onto that person, in a way that [you] can to the dentist or cartographer" (278). In cases of moral decision-making, an advisor must give you reasons, and then you must decide whether to accept those reasons are your own. If you do, then they are no longer the advisor's reasons.

Cowley defends the distinctness of morality by noting that much of the evidence for our moral beliefs is "direct and intuitive, without any plausible validating reasons that could be given." Further, the evidence is not only direct, it is often emotional, and therefore, "nonrational." Consider that, if you don't already experience a certain revulsion to an action, it is unlikely that you could be convinced that it is

[49] See John-Stewart Gordon (2014) for an argument that moral philosophers are not, contra Archard, committed to respecting common morality. And Dale Miller (2005) argues that J. S. Mill views the role of moral philosophers as going beyond common morality, critiquing and improving it.

wrong, even by an expert (277–278). Robert Hopkins (2007) calls this objection the *Unusability Argument* against moral testimony. The idea is that, in order to have a right to a moral belief—unlike a belief about physics or mathematics—one must meet a sufficiency requirement: "having the right to a moral belief requires one to grasp the moral grounds for it" (630). If one must understand the relevant grounds for oneself (feel a "natural repugnance," as Cowley puts it), and one cannot acquire that understanding from others, then moral testimony is *unusable*.

Interestingly, even if Hendel and Cowley are right about the distinctness of morality, it is not clear that this diminishes or undermines the role of moral experts. If a moral expert provides you with reasons you had not previously considered, then even if those reasons become your own, you may be better positioned to make good moral decisions. Elizabeth Anscombe (1981) and Karen Jones (1999) addressed the uniqueness problem—and its corollary, the unusability argument—along these lines. Anscombe contends that there is at least one sense in which morality is not unique: "[O]nly a foolish person thinks that his own conscience is the last word… about what to do. … [A]ny reasonable man knows that what one has conscientiously decided on may later conscientiously regret" (46). And Jones writes that, "just as borrowing scientific knowledge can enhance our capacity to discover truths about the nonmoral world, borrowing moral knowledge can enhance our capacity to understand the world of value" (56).

Further, it might be that moral expertise does not require or presume to transmit distinctly moral knowledge by testimony. If the primary expertise of CECs is in bioethical mediation (see Dubler and Liebman, 2011), the primary content of their testimony may not be moral. Or, if the primary testimony of CECs is an "all things considered judgment" regarding the complex of moral and non-moral features of a medical decision (see Rasmussen 2016), then one might not need distinctly moral knowledge to provide epistemically authoritative advice.

1.3.7 What Is Moral Expertise About?

A final important debate is whether moral expertise requires that experts have *objective moral knowledge* or simply a *facility with moral reasoning*. As in the early cases of Broad (1952) and Ryle (1958), many critiques of moral expertise attack the idea that philosophers have privileged access to moral knowledge. In 2012, Martin Hoffman concluded that, "The scope of ethics expertise is limited to working out and explicating the logical structure and the empirical conditions of intricate moral problems. But it does not consist in genuine moral expertise, which allows the expert to have an epistemic access to esoteric moral knowledge" (305). And as recently at 2014, Edward J. Bergmann and Autumn Fiester wrote that "No ethicist possesses the moral wisdom to objectively rank the values at play in [conflicts where parties hold incommensurate values]" (703).

In response, many defenders of practical moral expertise have argued that ethicists do not, and need not, make any strong claim about having moral knowledge

(see Yoder 1998). What ethicists are really experts about, they purport, is moral *reasoning*.[50] In 1972, for example, Peter Singer made a case for the idea that ethicists were, at minimum: "more than ordinarily competent in argument and the detection of invalid inferences," able to understand and clarify "moral concepts and the logic of moral argument," and able to dedicate her full-time professional life to the study of moral issues (189). Singer concluded that a person with this background and skill set "may reasonably be expected to reach a soundly based conclusion more often than someone who is unfamiliar with moral concepts and moral arguments and has little time" (189).

What does Singer mean by a "soundly based conclusion"? He may be referring to deductive soundness, in which case, he is committed to the idea that moral experts have objective moral knowledge. Alternatively, he may be using sound in a more colloquial way, referring to conclusions that are well-reasoned and carefully inferred. It seems reasonable to think someone could draw a conclusion in the latter sense without arriving at objectively true beliefs. For example, when Olympic judges assign scores to an athletic performance, the scores are not "objectively true" (that's not the sort of thing Olympic scores are), but they are, nevertheless, based upon the judge's expertise in evaluating a variety of subtly technical features.

Of course, when it comes to subjects that are comprised of claims that are true or false, reasoning alone is not the only relevant goal. For instance, someone could devote extensive time to understanding the concepts and research practices of creation science and could, thereby, reach a soundly based conclusion (in some sense of "soundly based") within that subject. But such competence doesn't strike us as particularly useful for scientific decision-making. R. G. Frey (1978) criticized Singer along these lines, arguing that the whole point of reasoning well is to obtain more true beliefs: "[Q]uestions of moral expertise are not concerned with the skills that go to comprise the critical examination of moral issues but with the outcome of the use of those skills in terms of particular moral judgments" (48–49). This concern has clear affinities with the unusability argument against moral testimony: Why should ethics experts be content with their competence in moral reasoning if that reasoning is not arriving at conclusions that are likely to be true? Why would they offer testimony in the first place, and who should accept it?[51]

On the other hand, if they *are* arriving at conclusions that are likely to be true, why shy away from saying that experts have objective knowledge of morality? Can moral philosophers make such a claim? Bernward Gesang (2010) defends a qualified "yes." Gesang distinguishes stronger and weaker versions of competence in moral reasoning. He begins by distinguishing the ways experience in used in different fields. In science, for example, scientific theories must be adapted to fit

[50] See also David Adams, this volume (Chap. 12).

[51] Martin Hoffman (2012) draws a distinction between "ethics expertise" and "genuine moral expertise," arguing that, while moral philosophers might be competent to apply moral concepts to complex situations, it is a mistake to think that it gives them privileged access to "esoteric moral knowledge (304–306). This suggests that ethics experts might be trusted for their epistemic virtues even if they cannot dispense moral truths.

observation. "Moral experience," however, "is influenced by the concrete subject, its preferences, traditions, and so on" (156). The idea is that the role of theory and experience is flipped in the case of morality: theory helps to shape our moral judgments about experience. The opposite is true in science, where theory is shaped by experience and experimental results. This difference between science and ethics is supported by the fact that moral experience is not "intersubjectively reproducible," rendering it weaker than scientific experience.[52]

This does not, however, mean that moral philosophers do not have *any* epistemic advantage over anyone else. Gesang admits that moral philosophers will likely have beliefs that are "better founded and more likely to be right" than non-philosophers. Nevertheless, because their moral intuitions "are not intersubjectively reproducible" they cannot make strong claims to expertise like physicists. They cannot, for example, say to anyone "Your opinion is false" the way a physicist can" (158).

If Gesang is right, the fact that moral judgments are weaker than scientific judgments means that ethics consultants could not be experts in the same way that scientists can. They can, however, be "semi-experts." Moreover, this might help explain the reticence to regard CECs as moral experts, thus suggesting new ways of explaining and acknowledging the role that CECs should have in medical decision-making. Gesang's conclusion, however, may render CECs' judgments too weak. If a patient's family member were to say, "Cutting off limbs is never ethically permissible under *any* circumstances," it would be strange to think an ethics consultant could not justifiably respond (with some tact), "False!" Nevertheless, much work is needed on identifying precisely what sort of judgments CECs can offer and which are necessary for practical moral expertise.

1.4 Recent Developments

In 2005, Lisa Rasmussen published a collection of essays addressing a number of these topics.[53] Contributors to that volume pushed the debate forward in a number of ways, clarifying historical perspectives, exploring the public implications of moral expertise, and rendering more palatable the idea that ethics consultants can

[52] Gesang's conclusion depends on adopting what he calls the "coherence theory of moral justification," which he contrasts with the "deductive theory." We won't rehearse these details here but will simply note that whether one adopts the coherence theory affects the plausibility of Gesang's conclusion. See Cowley (2012) for a critique of Gesang.

[53] Rasmussen (2005). Rasmussen (2011) distinguishes between "ethics expertise" and "moral expertise" as a heuristic to help distinguish the sorts of epistemic authority CECs might possess. Though there is no widely accepted account of the sorts of recommendations that ethicists can make, one may think that CECs can make decisive recommendations that effectively and objectively resolve moral dispute (what she calls "moral expertise"). She argues that this is not the sort of expertise a CEC could plausibly have, and argues, instead, that they have "ethics expertise," the authority to offer "non-normatively binding recommendations grounded in a pervasive ethos or practice within a particular context" (650).

speak as authorities in a variety of roles. In addition to the need to follow-up on these conversations, a number of important shifts have occurred since Rasmussen's volume. We will briefly highlight two.

The American Society for Bioethics and Humanities (ASBH) is the largest professional organization for CECs in the United States.[54] At the time of Rasmussen's anthology, the ASBH had seemingly rejected the idea that CECs are moral experts. In the first edition of their *Core Competencies for Health Care Ethics Consultation* they expressly cautioned against the idea that CECs "have special standing in ethical decision making" for fear of "displacing providers and patients as the primary moral decision makers at the bedside" (1998: 31). The organization was especially concerned to prevent abuses in clinical ethics practice, such as CECs' imposing their own values on clinicians, patients, or families.

In 2011, the ASBH updated the *Core Competencies*, which now expresses an openness to ethicists' "sharing expertise": "…a consultant may be asked to share his or her ethics knowledge and expertise as it relates to a broad ethics topic, such as terminal sedation as a palliative intervention at the institution." This version also states that CECs can be warranted in making singular recommendations regarding whether a plan of care is unethical or whether only one course of action is ethically justified (8).

Though this language admits of a great deal of latitude in interpretation, it nevertheless represents a sea change in the way CECs view themselves and present themselves to professional medicine (at least in the United States). Assessing whether such a change is warranted, and if so, how the language here is plausibly interpreted are issues addressed in this volume.

This volume also includes perspectives from those working outside the U.S. context, where ethics consultation has evolved differently, though with many of the same aims. In the U.S., consultation models tend to take one of three forms: a multidisciplinary committee, a team of one or two consultants, or an individual consultant model. Members of these services typically include physicians, nurses, social workers, case managers, risk managers, legal counsel, spiritual care, and ethicists. Members may or may not have formal training in ethics, though are regularly pushes from within the ASBH to formalize a credentialing process for consultants. Regardless of the type of model, the consultation service tends to be requested while there are active questions regarding a patient's care, that is, while a patient is admitted and care decisions are being made.[55] And in all three models, an opinion regarding those decisions is offered, whether in the form of a recommendation or set of morally reasonable options, and that opinion is entered into the patient's medical record.

[54] There are some organizations and professional groups for clinical ethics consultants in other geographic regions. For example, the Canadian Bioethics Society holds an annual conference and offers some resources for ethics consultants.

[55] There are exceptions to this. For instance, many committees also engage in reviews of previous cases for purposes of education and quality improvement.