Professional Medical Ethicist: A Weed or Desired Member in Medical Ethics Debates?

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Abstract:
We now live in an era of experts on virtually everything, among which we have professional medical ethicists, who gained prominence in the late 60s due to dramatic advances in medical technology. Before then, medical ethics issues were not thought as separable from the warp and woof of the everyday life. Medical technology’s advancement cascades legions of moral problems in medicine and biomedical research. Series of innovative interventions in medicine raise throngs of ethical questions. In most cases that have to do with issues of life and death, there are perceived moral conflicts. Due to this swath of problematic issues that need solutions, some apologists favour medical ethics experts as fit for the job, while critics argue that no one has the knowledge or skill for dealing with moral quandaries because objective truth is not feasible in ethics and moral judgment is relative to cultures, beliefs and values. The necessity for medical ethicists to take active role in Medical Ethics Debates, either in Committees at the institutional level, or at any other decision-making mechanisms is justified in this thesis. In addition to this, the thesis also justifies medical ethicists’ role as expert consultants to clinicians and individuals alike. This justification is based on complex moral problems accentuated by medical technology, which are far from being easily solved through mere appeal to individual reason, but rather by involving medical ethicists based on their specialized knowledge and high level understanding of research and practice. Although critics question the authority with which experts speak on these issues, nevertheless, the thesis unravels the roles, functions, significance and components of expert’s expertise that separate him/her from the crowd. Arguments are critically analysed and medical ethicists’ limits and professional flaws are addressed, with a view to establishing a virile foundation for the profession of medical ethics.

Key Words: Medical Ethics Debates, Medical Ethicist, Consultants/Experts, Medical Ethics Profession, Moral Problems, Medical Ethics Committees.

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Chapter 1

1.0 Introduction

“The question I’m interested in is what role a moral philosopher’s own moral perspective or judgements should play in the advice she gives, or the contribution she makes to the decision-making, on an ethical problem of public concern. Do the moral judgements of a moral philosopher have a different standing from those of the rest of the community in virtue of her professional expertise? Unless they do, it seems to me it would be unprofessional to put them forward in the context of a professional opinion or consultation; moreover doing so has ethical implications.” (Crosthwaite 1995:362).

1.1 Background

The growth of bioethics as a discipline has lent credence to a large number of ethicists and ethical experts. For example, the physicians are faced with moral problems in their daily practices, which are expected to be resolved using their moral lights. In the late 20th century, solutions to moral quandaries have become the domain of ethics experts. Advances in medical technology orchestrate huge moral problems which ethicists are thought to be better at solving than physicians. Ethics experts seem to dominate scene on issues relating to conflict between hospital and patient over treatment, public-policy impasse, and in fact, they are no longer restricted to biomedical professions.

Ethics experts are now answering some of the definitive moral questions of our age, such as questions relating to cloning and stem-cell research, and also appear in courts as expert witnesses. In addition, ethics experts provide testimony in descriptive and normative ethics. On this basis, critics have questioned the authority with which ethics experts speak on these issues. They argue that ethics is not a subject like Physics where expert’s role could be assumed, that professional ethicists are not better qualified to make sound ethical decisions than anyone else, and that an ethicist merely or simply states the obvious, i.e. what a professional ethicist claims to do is nothing beyond the comprehension of an ordinary individual who is not an ethicist. Put in another way, the pieces of advice that might be given
by an ethicist have no special meaning that could not be understood by others by the sole of
their own reason.

The role of ethicists or ethics experts in issues affecting daily life has been under sharp
criticisms from those who do not have belief in such specialized knowledge, and they see it as
irrelevant. The belief among those who are indeed against professional ethicists is that
individual reasoning could solve some tasks assigned to these experts.

Let’s take a look at the role of experts in Research Ethics Committees (REC) at the
institutional level in order to prove a point. It is a common phenomenon or trend nowadays --
though not in all European countries -- to include ethicists and other lay persons in Medical
Ethics Committees and other public debates pertaining to medical ethics. The call for ethicists
in these committees and debates is premised on their moral and philosophical inclinations
which might have significant impact on decisions, judgments and pieces of advice given.
Since ethicists are now on REC’s seat, any attack direct at REC is invariably or presumably
against expert’s judgments on various cases before REC.

For example, Edwards et al, (2004:420) argue that Research Ethics Committee’s rejection
of research that poses risk to competent people is not plausible because “Individual recruits
are in the best position to say what risks are reasonable for them”. They go further to
speculate that REC’s role could be taken care of by what they called “a solitary research
information officer [who] signs off the patient information sheet as being suitably
transparent”. The idea mooted by the authors on the use of a solitary research officer is a way
of rejecting expert’s knowledge in such cases. This is inappropriate because a solitary
research information officer’s skills are not the same with those of ethicists by virtue of their
training. The questions here are: Is individual’s reason sufficient in making a moral choices or
arriving at an ethical conclusion? Don’t we need more clarifications beyond ordinary reason?

Other arguments leveled against the idea of expertise in ethics range from the belief that
experts could hardly be gathered under the same conceptual umbrella; that we all know right
from wrong; that morality is based on feeling and as such it is not the stock and trade of ethics
experts because it is either learned or inherited; that all moral reasoning is based on
assumptions, and decisions on different issues are relative. These are few of the punches
thrown at ethicists which may cast doubts on their existence and practice, and the question of
why then do we need ethicists? All these would be examined in the course of this study.
1.2 The Research Focus

This thesis focuses on the role a medical ethicist plays in medical ethics debates, most especially in Medical Ethics Committees at the institutional level, although an ethicist inclusion at other medical committees on a higher level is, perhaps -- according to some opinions -- equally more justified. The study argues in favour of a distinctive role and function of an ethicist in contributing to finding solutions to problems where ethical issues are to be addressed. The study also considers the expertise an ethicist stands to offer in major classic cases in medical ethics. According to Crosthwaite (1995:362), when ethics committees evaluate health research and innovative treatment proposals, the need for the expertise of a philosophically trained ethicist could not be over-emphasized. His reason is based on the premise that the involvement of a philosophically trained ethicist goes beyond ordinary deliberation of practical ethical issues, but necessity of philosophical contribution to such debate is crucial and pertinent in order to shape the direction of the debate.

In part, the discussion focuses on the expertise of an ethicist in relation to moral conflicts propelled by medical technology advancements, and general questions about morality; and how he/she uses philosophical reflection to help in unraveling these problematic moral issues. Arguments are advanced for the necessity of including an ethicist in various Ethics Committees such as Health Care Ethics Committees (HECs), Research Ethics Committees (RECs), and Institutional Review Boards (IRBs). It is argued that most of these committees function effectively without the contributions of an ethicist, but I contend that employing an ethicist in these committees engenders virile criticism, refutation and modification of views based on his/her training, philosophical knowledge and professional expertise. Although it has been argued that it is not the business of the philosopher to tell people how to live, that people can, and should, make such decisions for themselves, nevertheless it is believed that an ethicist helps to clarify terms and arguments, and assist people in making decisions (Norman 1998:2).

This paper highlights theoretical, conceptual and practical situations that serve as benchmarks against which to judge the expertise of an ethicist. It examines the kind of expertise that makes an ethicist a professional in his/her own right, which qualify him/her to deal with broad moral issues. Various critical counter arguments and limits of ethics expert are equally explicated. Noticeable professional flaws in ethics practice are as well addressed in order to
secure the future of medical ethics as a discipline and to ensure experts’ expertise general acceptance.

### 1.3 Research Questions

Several questions are at the heart of this research, but the major ones that bear direct relevance to the topic under study are:

- Is there any need for professional medical ethicist’s presence in medical ethics debates or Medical Ethics Committees?
- Is individual’s reason not sufficient to arrive at an ethical conclusion or make a moral choice?
- Are various Medical Ethics committees not better off without an expert medical ethicist?
- What sort of expertise can a medical ethicist offer in medical ethics debates or committees?
- What differentiates an expert medical ethicist from non-expert or ordinary committee member?
- Of what use can we put an expert medical ethicist’s expertise?

I intend to evaluate these questions in the subsequent chapters of the study. Arguments are put forward in favor of professional ethics and professional medical ethicists. Also, functions of ethics committees and how an ethicist fits in any of the committees are to be discussed.

I am equally poised to elucidate on the significance and limitations of reason on ethical choice or judgment, and the need to search for more clarifications on how subjects, participants or affected parties in moral dilemmas might make moral choices beyond appealing solely to their individual reasons.

It is my intention to address the necessity of a medical ethicist in a Medical Ethics Committee, and perhaps, show that Medical Ethics Committees might be better off with an expert medical ethicist rather than without him/her. According to Bryant et al., “As far as modern medicine and biotechnology are concerned, ethicists still have a role to play…and others who know about risks and safety, while sociologists, psychologists, policy makers and politicians who know about people’s reactions and public opinions also have a significant role.” (2002:8). The assumption here is that if we gather different professionals and laypersons to discuss moral problems, we still need an ethicist whose interdisciplinary
knowledge might bear on the discussion of the issues, in addition to what other professionals have to offer.

Besides, distinguishable attributes of an ethicist, most importantly his/her training and comprehension of moral theories, which separates him/her from ordinary committee member, would be evaluated. Arguments and counter arguments against an expert ethicist will be critically examined, reasons behind normative proposals for the inclusion of an ethicist in moral debate are to be discussed, and the future of an ethicist in moral debate would be analyzed. In doing these, it is my desire to contribute to debates on acquisition of an expertise in the field of ethics, and to give affected interests opportunity to assess the significance of such professionalism.

1.4 Layout and Methods

Chapter 2 deals with review of textbooks, published articles and journals related to ethics in general, in order to apply cases to my area of research, where literature is less readily available. Notwithstanding, I would strive to review available texts, journals and publications relating specifically to professional medical ethics. This would serve as a model or support for the clarification of concepts, frameworks/theories that lend credence to arguments in favour of, and against an expert medical ethicist. Philosophical theory that upholds the relevance of an expert ethicist, and the one that rejects the idea of an expert ethicist shall be assessed with a view to balancing the role a medical ethicist plays in clinical and medical ethics debates.

Chapter 3 treats distinguishable traits of a medical ethicist from that of ordinary lay men in Medical Ethics Committees and medical ethics debates, how he/she may claim to be an expert in the field, where his/her expertise lies, and the fruits his/her expertise might bear in complex medical ethics discussion.

Chapter 4 analyses the reasons supporting normative proposals for ethicists in ethics debates, the future of a medical ethicist in moral debates connecting to medical issues, including proposals for forging consensus on complex moral issues, protecting objective judgments of members, and defending normative claims and positions in order to develop understanding on moral disagreement.

In relation to the methods, a normative study is conducted. A normative study involves a situation where subjective views are defended, where references are made to characteristics of the subject matter rather than exact numerical strength, and where assessments are only indicative of relative meaning rather than objective ones. It is important to note that in any
form of study, be it normative, qualitative or quantitative; the choice of sources or data represents some elements of value of the researcher.

This study tries to address a question of “What ought to be the practice” in medical ethics, i.e. the need to accord medical ethics a professional status, and to recognize the distinctive roles and functions of medical ethicists in any Medical Ethics Committee and in complex medical ethics debates. According to Imwinkelried (2005:200), normative study could be either prescriptive, where certain conducts are required, or it could be prescriptive, where certain particular behaviours are forbidden. In all, the content of normative study is value-laden, rather than content of historical fact.

Most of the data that support my arguments are obtained from secondary sources such as textbooks, journals and published articles, including, perhaps, the use of the internet. It is from all these sources that inferences are drawn to back-up my arguments in favour of a professional medical ethicist’s inclusion in any form of Medical Ethics Committees, and as a consultant and expert on medical ethics issues.

1.5 Limitations of the Study

It is incumbent upon me -- before I begin an analysis of concepts, frameworks and theories that clarify my position -- to give a synopsis of inherent limitations of this research in order to limit various objections and criticisms from readers which the study may arouse.

To start with, the plague of scarce data on both general and specific role a medical ethicist may play in different Medical Ethics Committees, and data that demarcate different kinds of expertise required of a medical ethicist at each Committee nearly distract me from forging ahead. Nevertheless, application of an ethicist’s expert knowledge in order areas of endeavours such as: as a witness in court rooms, in clinical ethics consultation, and healthcare consultation spurred my desire to dig deep into the necessity of a medical ethicist’s contribution to medical ethics debates and involvement in Medical Ethics Committees.

I am aware of the challenges I am to face in carrying out this research because there are incomprehensive and limited sources or avenues available to provide answers to questions like: Is there any need for professional medical ethicist’s presence in medical ethics debates and Medical Ethics Committees? Are various Medical Ethics Committees not better off without a medical ethicist? In essence, definitive conclusions about these issues are almost nearly impossible, better still, the proposition that a medical ethicist is highly significant or relevant in the discussion of complex moral and medical issues cannot be over-emphasized.
This is more so because of his/her professional leaning -- like in any other established professions -- acquired in the process of his training in philosophy and moral issues. Hence, the aspersions cast against a professional medical ethicist may, after all be unfounded. I make this statement based on my own assumptions, verifiable scholarly facts from journals, and academic propositions from textbooks and published articles.

In addition to the above, I identify different ways in which people perceive ethics, morality and an ethicist. It is obvious from layman’s comments and scholarly publications that different people and disciplines claim authority on moral issues, and as such, the role of an ethicist is not peculiar to a particular group of people and a specific discipline. In reality, therefore, such deception and ignorance proof difficult to be refuted based on the fact that no one can claim to have knowledge of moral truth at the exclusion of others. As far as this could be upheld, I endeavor to look at the criteria that qualify one as an ethicist, beyond which every individual may assume to be a fit. This undoubtedly may be subject to criticism, but better still, it is necessary to separate the wheat from the chaff.

Lastly, I base most of my analysis and description of the subject matter on secondary sources -- textbooks, journals, articles, and the internet -- in order to evaluate information about roles, duties, impact, and significance of a medical ethicist in any Medical Ethics Committee. I rely basically on analyses of previous and related studies in order to generate a new perspective that could be of immense value in addressing complex medical ethics issues, built around not only lay perspectives, but with an inclusion, and employment of a professional medical ethicist.

With all these background information and inherent limitations, the stage is now set for concrete presentation of issues upon which the study rested.
Chapter 2

2.0 Introduction

According to Taylor and Procter (2005), literature review conveys to readers knowledge and ideas that have been established on a topic, including their strengths and weaknesses.

In this section, the following sub-divisions would be reviewed or analysed: conceptual definition of terms; the roles, functions and significance of ethics experts in Medical Ethics Committees; theoretical exposition of the relevance or otherwise of a medical ethicist’s expertise; and critical analyses of the need for professional medical ethicist in Medical Ethics Committees and medical ethics debates.

2.1 Conceptual Definition of Terms

2.1.1 Definition of Expertise and Ethics Expertise

By “expertise”, I refer to skills or knowledge that qualifies an ethicist or a medical ethicist to make a claim as a professional. I contend that different professions have such skill base and special knowledge, even though, others outside such professions might be knowledgeable to a limited extent in those areas. Although ethics expertise seems to be controversial, due to the fact that there is nothing like objective truth (answer), there is no expert knowledge of right and wrong, and specialization in ethics, perhaps, is not feasible. I argue that there are skills that support this claim to expertise.

In my own conception, “ethics expertise” does not connote knowledge to provide definitive answer, claim to an objective truth, rather, it means what Fletcher (1998:11) describes as, identification, understanding, and aiding agents to resolve ethical problems. Crosthwaite (1998:11) again substantiates what sort of expertise is required of an ethicist. She argues that, “… it is appropriate for the moral philosopher who is consulted on a moral problem not only to lay out the different moral positions with their rationales, strengths, and weaknesses, but also to provide a considered judgment about the best alternative”. From the foregoing, I believe that even if critics affirm that ethicist’s ability is limited due to ethical relativism, application of reason; those who are provided with pieces of advice by an ethics expert, i.e. subjects concerned, have discretionary power to accept or reject his/her verdict or advice on moral issues.
2.1.2 A Specialist and an Expert

There are widespread opinions that specialization is impossible in ethics, which is the bedrock of another criticism against a claim to expertise. This leads to the distinction between being a specialist and an expert. These two concepts are not synonymous. Weinstein (1998:11) clarifies that: “…a specialist is an expert, but an expert need not be a specialist. We can think of expertise in terms of generalization as well as specialization, of breadth and integration of knowledge as well as depth of knowledge”. What I may deduce from here is that expertise does not require mastery of specific or particular body of knowledge, but ability to decipher knowledge from other fields (i.e. interdisciplinary knowledge).

Based on this background knowledge of the kinds of expertise required of a professional ethicist, I would endeavor to explain why these expertises are relevant for subjects’ decisions on medical ethics issues. I do not claim that individuals are not their own moral legislators, but availing themselves the opportunity of a medical ethics expert may provide succor in ethical dilemma. First, I am going to discuss historical antecedent of Medical Ethics Committees and developments that led to the growth of Ethics Experts/Consultants.

2.2 Ethics Committees and Ethics Experts/Consultants

I am referring here to ethics committees and professional ethicists in general, although according to Moreno (2001: 475), they are part of the phenomena associated with bioethics and they both reach back to the ancient origins of medical ethics. Bioethics -- most especially in United States of America -- has revolutionized doctor-patient relations, and it has according to Moreno (2001:481), established itself as an agent for the development of a new consensus on diverse, and barrage of moral quandaries consequent upon introduction of biomedical technologies. In a way, there is the need for deliberations on issues like when and how to die, due to individual sovereignty; and evaluation of existing risks in decisions taken both by physicians and patients on issues of life, death and choice of medical technologies to prolong life.

Some of these vehicles of consensus at the institutional levels are the primary concern of this thesis. These vehicles are Medical Ethics Committees and medical ethics experts or consultants. At the institutional levels -- for instance in United States of America and The Netherlands -- some of these committees are: Research Ethics Committees (RECs), Health Ethics Committees, and Institutional Review Boards (IRBs). A Research Ethics Committee is established for the purpose of protecting potential research participants from unnecessary and
avoidable harm. It draws its representatives or members from the wider community, with the sole purpose of coming to an agreement on moral issues through the process of deliberation and consensus. Institutional Review Board’s (IRB) significance lies in its evaluation of the ethical conduct of human research. According to Annas (1991: 18), investigators have to justify their research on humans to a peer review group prior to recruiting subjects, and by doing so, it provides ethical and legal cover that enabled experiments to be performed that otherwise would not have been because of their potentially devastating impact on human subjects. IRB assesses or reviews research protocols, most essentially to make a clear assessment of risk and benefit, and like any other Medical Ethics Committee, to promote moral reflection among the researchers who are expected to consult the board on research proposals. Annas (1991: 18) argues that the failure of IRBs could be traced to lack of expertise concerning particularly novel or complex research proposals. Justifying this further, Schülken (1997:46-49) affirms that “…all too often there are no qualified ethicists on ethics committees, because ethics is still confused with a particular strain of sectarian Christian morality”.

This is why it is not proposed that these vehicles of change should work in isolation of the other, rather the intention is to establish that joint participation or involvement of a medical ethics expert or consultant in a Medical Ethics Committee might provoke a valid, sound and consensual moral decisions and judgments. Though consensus is not a necessary condition for a solution to a moral problem, it might be a good starting point to arrive at an acceptable outcome. I sum up with this quotation:

Setting up an additional bureaucratic entity called an ethics committee to make legal pronouncements can only make medicine more legalistic and impersonal. Moreover, encouraging a group of lay people to attempt to practice law makes no more sense than encouraging a group of lawyers to attempt to perform surgery (Annas, 1991: 18)

The above statement reveals that the justification for ethics committees is neither to usurp the roles of the legal institutions nor to fill them up with people without expert knowledge about ethical issues. The essence of the committee is rooted in the need for multidisciplinary members of the community who are reflective and have abilities to make standard decisions on ethical issues affecting the community’s institutions. Therefore, a combination of both lay
and expert perspectives might engender an acceptable public opinion in response to moral issues, and dissuade any community from disapproving these committee’s recommendations.

2.2.1 Ethics Consultants/Experts

Early in the history of medicine, the issues relating to decisions on moral standing rested with the physicians. In those periods, doctors had the prerogative for reflecting on the questions of ethics and decisions required by patients on issues bothering care and life. Nowadays, ethics consultation or expert advice are offered not only by doctors of medicine, but by what Ackerman (1989) calls a non-physician whose sole function is ethical rather than medical assistance. They are part of ethics decision-making mechanisms -- including ethics committees -- put in place, and they are accessible to hospitals, patients and families. Moreno (2001:476), affirms that the occupation might be linked with the historical functions of the hospital chaplains, theologians and academic philosophers who were interested in the clinical setting, including ethics committees members who offered their services for helping with emergent ethical disputes in the 1970s (Rothman, 1991). This change in role and function is, perhaps, attributable to complex modern administration and bureaucracy, and in modern day society, some professional ethics consultants work as independent entrepreneurs in positions supported by hospitals.

A common scenario today -- from examples in Netherlands and the USA -- is that expert ethicists or consultants partner with various ethics committees in order to deliberate on complex moral issues that need some form of moral resolutions. Besides, there is also a shift from the emphasis on the values of non-maleficence and beneficence, rather what we have today is experts or ethicists’ concern with other values such as autonomy and justice. This portrays the fact that the modern ethicists or ethics consultants are undeniably a product of the bioethics movement -- championed in the US -- for which autonomy is the usual ethical ‘trump’ (Moreno, 2001:476). This is suggestive of the fact that physicians’ duties and roles as healers need to be separated rather than extend to ethics consultation as it were the case in the early history of medicine. In other words, Moreno (2001:476) emphasizes that Hippocratic physician was a solo practitioner who needed no moral advice of a committee, and certainly not a committee dominantly comprised of non-physician. As more and more complex ethical cases are arisen in the modern day era, ethicist’s role or function as arbiter on ethical issues rather than medical assistance is desired. This form of role specification and clarification in
hard cases was equally counseled by Hippocratic authors, though they never anticipated a non-physician consultant on moral issues (Ackerman, 1989).

With the arrival on the scene of the new sort of specialist -- medical ethicist -- moral questions are now handled at various levels, such as at the Health Committees of the Congress (USA), Public Health Service, at biotechnology and managed care companies, and at hundreds of clinics and hospitals (Satel & Stolba, 2001:37, ). In fact, any medical ethicist believes that his/her presence in a committee does well to it, or/and at bedside in the hospitals does well to both the patients and the doctors alike. The good it does, is to encourage doctors “…to give full consideration to certain key principles in resolving clinical dilemmas. Among these principles are the traditional -- if vague -- obligations to act for their patients’ benefit and to avoid harming them. In a more modern vein, doctors are urged to respect the “autonomy” of those whom they care for, which typically means obtaining their informed consent for any course of treatment” (Satel & Stolba, 2001:37).

From the foregoing, explicating of key ethical principles either to physicians, or Medical Ethics Committee members, is a significant role that we may not ignore. Clarifications on principles of autonomy and issues bordering informed consent of patients or research subjects are vital basis for moral resolution. While a medical ethicist’s role seems to be a way of restricting physicians on their own job description, it might be helpful on the other hand to leave human side of the equation to experts who are knowledgeable in that aspect. In other words if responsibilities are shared -- most especially on delicate and complex issues relating to life and death – it eases decision-making process and simplifies tasks.

The operation of ethics consultants, according to Moreno (2001:480) is organized in two models described by him as ‘soft’ and ‘hard’ models. In the soft model, an ethicist functions to bring various parties involved in ethical dilemmas together, help clarify the issues at stake and arrange a mutually acceptable resolution (Ackerman, 1989). The hard model involves ethicist’s evaluation of the patient’s condition, identifies the relevant medical, social, legal and ethical facts and issues a recommendation (LaPuma & Schiedermayer, 1991).

It is clear from the above that there is no doubting the fact that the role of an ethicist or an ethics consultant is an ambiguous one, based on the following: the yardstick to measure the criteria for professional ethical practice; the choice of model for the evaluation of a case; and vulnerability of an ethicist to employers’ whims and caprices, and inability to take a principled stand and guide against tampering with professional integrity for fear of reprisal. All these seem to work against acceptance or recognition of ethicists in ethics committees or their abilities to make a difference in these committees. But at the same time, as a growing
profession, these lapses are expected to be addressed by establishing a Professional Ethicists’ Guild that coordinates activities of members in order to avoid marginalization of their professional practice.

The hindrance ab initio to ethics consultation or ethicist’s expert knowledge has now waned, due to younger physicians’ embrace of ethicist’s moral guidance, and the use of ethics consultation “… as an opportunity to ‘turf’ a complex and legally ominous issue.” (Moreno, 2001:480-481). It is believed that ethics consultants provide ‘ethical cover’ in tough cases, and as such, it is an avenue to pass responsibility for decisions that is born in ambiguity and which can provoke anxiety among physicians. So, for experts to remain a force to be reckoned with in ethics committees, they need to prove themselves worthy of the positions they occupy in these committees and justify their inclusions.

Since soft, tough and hard cases are referred to these committees with respect to the use of medical technologies, human subjects in research and other complex moral issues, contributions of an expert on a committee, to provide valid reasoned judgments on these issues is quiet essential. From assessment of such ability, we can determine the relevance of an expert in a committee, either as a permanent or temporal component of modern health-care decision making. This is why it is significant for ethics experts to possess, according to Moreno (2001:482), “… several characteristics, including analytical discernment and a knowledge of medical ethical issues and the relevant literature”. Besides, Moreno (2001:480) adds that, “At a minimum, the competent ethics consultant must speak the languages of medicine, law and ethics, must be interpersonally skilled and cognizant of social-psychological issues and must have ability to inspire confidence”. All these features are not ever-present in all committee members alike, and the possession of such features by an expert member on a committee might make a lot of differences in the process of deliberation, and at the point of reaching conclusion on moral issues.

2.2.3 Ethics Committees

As pointed out in the previous section, some medical ethics committees like RECs and IRBs are representatives of divergent perspectives within a community. According to Lundberg (1993), “… ethics committees help to develop practice guidelines for their institutions to identify when treatment may be withheld on grounds of (so-called) futility”. An ethic committee idea is legitimized as an expression of certain themes of democratic liberalism, with the notion that moral controversies are at best tackled through multiple
perspectives on the nature of the good life (Moreno, 2001:477). The three commonly agreed functions of ethics committees are: case review, policy advice and staff education. It is important to note that there are wide discrepancies among ethics committees: some report to the hospital’s organized medical staff; others report directly to administration; some are passive and de-emphasize bedside consulting; and others have active leadership and try to assert a presence on the wards.

Specific interest is on those committees that include members who are familiar with bioethics literature and theory (Moreno, 2001:478), and members who are trained in practical philosophy with a comprehensive reflective ability and competence. I do not lean my weight to committees whose members have had virtually no previous experience with ethical analysis because solutions to moral problems, clarifications and reflections on moral issues, and helping those who are faced with moral problems in decision making should go beyond lay perspectives alone. Contrary to the view of Moreno (2001:482), it is not that a body of ethics experts is being advocated to be the nucleus of any ethics committee, but at the same time, an idea that a well-integrated groups composed of individuals who are respected within the institution -- without an inclusion of an ethics expert -- are powerful agents of change is neither affirmed nor supported.

The argument from above is that an ethicist’s inclusion in a committee that discusses moral issues either at institutional or other higher levels is desirable because a committee that is a bunch of people with no prior knowledge of ethical evaluation, which is a function of expertise acquired from training in practical philosophy and other multidisciplinary areas, may not be competent enough to educate people on moral choices available to them. It shows that a medical ethicist’s expertise is relevant for committees, research subjects, health workers, patients, e.t.c. to reflect on the implications of their own decisions in the face of a dilemma.

Unarguably, the role of experts in Medical Ethics Committees remains a bone of contention. It can be argued that concerns for an ethics expert threaten individual sovereignty and promotes rave for decision making by relatively disinterested specialists or experts who might use their positions to influence their own moral agenda. Nevertheless, the counterargument is that experts’ roles may be legitimate in these committees in some circumstances, such as the need to justify a research on humans before recruiting subjects. Evaluation of complex research proposal requires the services of an expert ethicist. I hold the belief that an ethicist reinforces individual’s freedom to choose, and as an expert, he/she detaches from personal interest to promote interests of the general public in order to uphold
his/her professional integrity. Some critical theoretical expositions of experts’ roles with respect to moral issues are addressed in the subsequent section.

2.3 Moral Theory and the Role of Ethics Experts.

In this section, practical ethics and Aristotle’s conception of rhetoric and contributions of David McNaughton on morality are evaluated with regards to the views on expert’s expertise. The choice of these two writers is based on their different extremes on expert’s expertise and his/her desirability to engender reflection in people, on choices to make when confronted with moral dilemma. While Aristotle debunks existence of such technical ability of an individual, McNaughton embraces expert’s competence in resolving moral chaos. The whole exercise tends toward elucidating expert’s relevance, functions and roles in ethical debates, from which my own normative conclusion is drawn.

According to Marino (2001), Aristotle is the last person that would ring up for an ethics consult. He substantiates this argument thus; “It is the virtuous individual, and not necessarily the scholar who has been studying ethical case histories, who will have the most acute moral sensibilities”. Closely allied to this argument is the one supplied by Almond (1997:420), according to her, Aristotle maintains that practical wisdom is not the prerogative of the few, rather, it is accessible to everyone.

By inference Aristotle believes that it is not an official right of anyone to claim specialized knowledge in ethical issues, to give moral counsel or pass moral judgment, in fact such scholarship may not be sufficient because they could not be likened to those set of virtuous people or moralists called ‘moral paragons’ (Marino, 2001). I would disagree with these assumptions soonest.

In the same vein, London’s (2001) interpretation of Aristotle’s rhetoric and practical ethics is note-worthy. According to him, practical ethics and Aristotle’s conception of rhetoric deal with normative issues, and these are common to all people. So when individuals are faced with different moral choices, they are expected to be left alone to assess the merits of all possible courses of actions and make a choice. He points out that “such matters [could be] deliberated upon without the knowledge of specialized arts or professions (techne) to guide us” (London, 2001:95). Aristotle asserts that rhetoric is primarily concerned with normative questions and we do not need to appeal to experts to answer or settle them for us:
…in part because they are not the special province of any technical discipline, and in part because they involve us in a way that we cannot abdicate our responsibility to others…The aim of rhetoric is thus to facilitate deliberation between people who are free and equal where it is understood that ‘the free person exists for his own sake and not for the sake of someone else’ (London, 2001:95-96).

This seems to be a modest assumption, but I submit that expertise of an ethicist, based on the skills that would be discussed later on qualifies him beyond just a facilitator and a commoner. In some instances, second opinion of others may make more sense than an individual reason without giving up one’s sovereignty or shedding one’s responsibility to another. An expert assessment of one’s situation may yield positive fruits than an isolated individual thinking on the same situation, because as the saying goes, two heads may be better than just one!

The theory above bemoans the role of experts as those capable of providing (unbinding) answers to normative questions, rather it prefers they maintain a subtle role of facilitators, and engender reflection in an environment where all are free and equal. He argues that, “Without addressing the means of presenting others with reasons that engage their own powers of reflections and understanding, [use of experts] subverts the status of others as free and equal and poses a danger to a legitimate social cooperation” (London, 2001:96). Therefore, their crucial role in practical ethical inquiry according to London (2001:97) is ability to engage broad spectrum of interlocutors’ intellectual and affective capacities “…in order to ensure first, deliberators perceive the breadth and depth of the issues that must figure into their deliberations and, second, that they perceive them in a way that resonates with their understanding and assigns them proper weight”.

The inference that could be drawn from the emphasis above is that either on a REC or IRB, the weight of an ethics expert is not in anyway significant i.e. either in deliberation of decisions affecting an individual, group, or discussion among members of a committee on moral issues, each and everyone is equal in status. No one is that competent or has a role that is distinctively above those of others. Besides, ethics expertise -- if such exists at all -- might be limited only to provision of reasons and reflections that could engender social harmony.

Contrary to the views expressed above, McNaughton (2001:79) in his thesis on “Morality—Invention or Discovery?” drums up support for the significance of experts in moral deliberation. He argues that it is implausible to claim that morality is an area of
personal decision; a realm in which individuals exert control on what to do, and such individuals may only seek advice on what to do from experts, and that these experts have no authority to tell us how to live our lives. His position is premised on the basis that making moral choices and taking decisions on ethical issues by individual’s moral light may not be that simple after all. He sums up his views thus:

…it is often difficult, when faced with some pressing and perplexing moral problem, to discover which answer is the right one. If I am puzzled as to what I ought to do then I am likely to feel that what matters is not that the answer I arrive at should be mine, one for which I am prepared to assume ultimate responsibility, but that it be the correct answer. I do not think of my choice as determining the right answer; on the contrary, I wish my choice to be determined by the right answer… (Beauchamp, 2001:80).

In my own opinion, ability and expertise needed for individuals and groups to make moral choices might be provided by moral or ethics experts. They have the capacity to approach their practice with experience, draw from specific and related analogies and present the reality of the subject matter. From the intuitionists’ perspective, one may argue that ethics and ethics experts compare favorably with sciences and scientists. This is so because intuition has to do with understanding without apparent effort, quick and ready insight seemingly independent of previous experiences or empirical knowledge. Therefore, when we talk about ethics and ethics experts, application of intuition to solve moral problems, coupled with experience and practical knowledge are basic components of dealing with moral issues. So, when it comes to moral discourse, we can’t rule out certain group of people with some specific and distinct traits, knowledge and actions that surpass those of ordinary laymen. This supports the view of Pence (1998:3) that when committees meet to discuss moral conflicts and general questions about morality, philosophical reflection is a useful tool.

This tool also is what medical ethicist is using in helping physicians to prepare for medical decision making in line with the accepted ethical norms: such as obtaining informed consent for therapy; helping to clarify the important elements of informed consent; and issues relating to choice of death by a patient. The fact that one aspect of decision making is entrusted with experts may not connote that experts are replacing physicians or that we are making a caricature of medicine and ethics. Also, the concept that the ethics committee becomes some sort of jury before whom evidence is presented, which according to O’Rourke (1987) is
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described as a travesty of ethical decision making may not be true. In the real sense of it, the committee on which an ethicist serves is not a substitute for legal or judicial institution. This is so because medical ethicist’s role either to a physician or in a committee is to educate, and in some cases offer consultation.

O’Rourke (1987) argues that though the devotion of ethics committee is to educate agents, nevertheless, it requires knowledgeable members to be on the committee, who are deeply aware of the principles involved and issues in question. He stresses that “common sense does not suffice for sound ethical decisions…ethics committee should school itself in one or both sets of these principles [developed for pluralistic societies]”. He points out the fact that all forms of professions may serve on an ethics committee so that ethical decision should be based on public opinion, but not all those who are on this committee are qualified to be referred to as ethics experts. Ethics experts and consultants are those with abilities to analyze issues from well-reasoned ethical perspective. In addition to this:

Ethics consultants must be knowledgeable about moral reasoning and ethical theory, bioethical issues and concepts, health care systems, clinical context, the local health care institution and its policies, staff and patient beliefs and perspectives, accrediting organizations’ codes of ethics and professional conduct, and relevant health law. The character traits needed for ethics consultation include tolerance, patience, compassion, honesty, courage, prudence, humility, and integrity (Everyday Ethics for Nurses: [http://www.nurseslearning.com/courses/nurseweek/nw1700/c4/p05.htm](http://www.nurseslearning.com/courses/nurseweek/nw1700/c4/p05.htm))

Therefore, Medical Ethics Committees should endeavour to include medical ethicist in its deliberation for adequate and proper clarification of ethical issues being debated. It is believed that a group of people with different perspectives and knowledge might have sufficient wisdom to deal with moral issues than isolated individuals or people with only lay views. This assertion is buttressed thus:

Ethics committees are based on the idea that wisdom is not the product of an individual -- a Solon, a Solomon, a Socrates -- but of a group in which the ideal qualities are put together from different human sources, one knows the subject on the ground, one knows about ethical theories, one is an ordinary lay-member of the public who knows nothing of a technical nature
but a strong opinions about many things, and one, normally given the task of chairing the committee, knows about politics and money, what can be done and what those in charge of the public purse want done (Almond, 1997:429-430).

According to Schüklenk (1997: 46-49), people with good motives and people with lay perspectives are not an acceptable substitute for professional ethicists on ethics committees and it makes sense to involve professional ethicists in order to understand, analyze and solve complex ethical issues. In the same light, Michael Parker, a professor of bioethics at the Ethox Centre, University of Oxford in United Kingdom reiterates that, “The availability of an ethicist makes it possible for the Clinical Ethics Committee to provide relatively timely and flexible responses to health professionals. The clinical work of the ethicist can also act as a useful indicator of areas of practice in which there might be the need for policy development or education” (http://www.ethox.org.uk/reading/Guide/SectionA/appendixA8.htm).

The summation of O’Ruke, Schüklenk and Parker is that doing medical ethics is not a duty meant for everyone, but those with defined competence, assertiveness and authority in the relevant components of the discipline. They point out that gathering different geniuses from different fields of study is not a substitute or replacement for the role of an ethicist. It is true that everybody has a role to play in ethics committee, but a prejudice for an enviable position an ethicist assumes in a committee is not tolerable. He/she is not just a facilitator per excellence, at the same time he/she is imbued with ability to direct affairs of the committee to a logical conclusion, and for the interests of all parties concerned.

2.4 CONCLUSION

This chapter reveals key issues in medical ethics where medical ethicists might not be side-lined or over-looked. Medical technology’s progress which leads to hordes of moral problems in medicine requires medical ethicists to shift from the idea of working on part-time basis to a full-time professional. This might be so because lots of issues are to be deliberated upon, e.g. issues about life and death, evaluation of risks attending patients and physicians’ decisions on issues of life, death, and choice of medical technologies to extend life among others. Therefore, as more and more complex ethical cases are arisen in the modern day era, medical ethicists’ significance as arbiters on medical ethics issues is desirable.

It has been shown in a number of ways how a medical ethicist functions, his/her specific roles, and how he/she might be relevant in a Medical Ethics Committees, barring all forms of
controversies and lapses that characterize professional ethics practice. According to Walker “...eticists are architects of moral space within the health care setting, as well as mediators in the conversations taking place within that space” (www.questia.com). They instil in physicians confidence that might make decisions on moral issues to be lighter and easier through proper reflection and deep thinking on issues like; autonomy, informed consent and paternalism. Their presence on committees also gives a committee a wider perspective on ethical issues, and perhaps, general acceptability of consensus reached on such issues by the public.

The next chapter treats the distinguishable attributes of experts that single them out from lay members of the public, and those features that make their inclusion in Medical Ethics Committees a justifiable one. Other issues that will be dealt with in this chapter are: how the experts may claim to become experts in the field, where their expertise lies, and the fruits their expertise might bear in complex medical ethics’ discussion.
Chapter 3

3.0 Introduction

In the previous chapter, the roles, functions, and relevance of medical ethicists in committees at the institutional levels, such as the RECs and IRBs are discussed. While some apologists favour ethicist’s inclusion in these committees, other critics reject acquisition of a technical moral ability by an individual, because such competence threatens individuals’ equality, and encourage promotion of moral agenda of a few click. There has been huge furore and mind-boggling questions concerning the expertise of any ethicist, be it a medical ethicist or the other. The whole episode centers on the premise that: moral decision is governed by individual’s reason; decisions about moral issues are relative to culture, beliefs and values; individuals are their own moral legislators; that moral responsibilities fall on different individuals without any need for someone with a particular technical discipline to solve it for us; and that such claim to expertise is an encroachment on individual’s sovereignty, and indirect trespass on the roles and functions embedded in some other disciplines.

This chapter tries to explain distinctive features of an ethicist that marks him/her out from lay members of the society, and people with lay perspectives on Medical Ethics Committees. It discusses the roles played by relativism and limitations of individual’s reason in moral discourse. Attempt is also made here to give a viable and well defined professional persona of an ethicist and the nature of authority and expertise he/she possesses beyond ordinary application of instincts and reason to make moral choices in the face of moral dilemmas.

There are two competing perspectives on the nature of authority and expertise of a medical ethicist put forward by La Puma & Schiedermayer (1998), and Baylis et al. (1997:422-423). These are: first, a medical model which emphasizes the art and practice of medicine, ability to diagnose ethical problem and offer therapeutic solution -- expertise in this case rested with physicians and nurses based on ability to provide bedside examination and curbside consultation -- and their relationship with ethics committees is that of educator and policy consultant. This model relies basically on health workers as medical ethicists, and I consider this model a sub-medical ethics, in the sense that, physicians and nurses -- without additional medical ethics education -- are not deeply familiar with the terrain of what medical ethics is all about, rather they only have peripheral knowledge of it.

Secondly, there is an expertise that is rested with multidisciplinary construction of the role i.e. multidisciplinary or feeder-discipline model, with abilities, knowledge and character traits
the role ought to have. A feeder-discipline model presents medical ethics as a discipline that
draws its curriculum from different allied professions. A specific discipline might not serve
the purpose for which medical ethics is conceived; rather knowledge is drawn from wide and
varied background relating to medical ethics cases.

Zoloth-Dorfman & Rubin (1997:427) reiterate that Baylis et al model upholds ethicists’
ability to educate, facilitate, analyze, and resolve conflicts, based on their varied professional
backgrounds and diverse experiences. The concerns here have to do with the sort of persons
to do the work, the appropriate genre of their expertise, and the expert contributions they
make in committees. This model is a comprehensive one, under which an expert medical
ethicist falls. It involves deep-rooted understanding of vital components that make up the
body of medical ethics. It is a multidisciplinary approach and a medical ethicist acquires
diverse knowledge that enhances his/her professional status.

The attempt made here is not to debunk the opinion that individuals are jurors of their own
situations, or that individuals’ reasons might not be appropriate in making moral choices. The
argument is that an ethicist, like every other human being and any other professional,
possesses more than just intuitive and reasoning ability that might be useful to educate people,
in taking decisions on complex moral issues. Some of these attributes that are added to
individual intuition and reason are explicated below.

**3.1 Influence of Relativism and Limitations of Reason in Moral Decision.**

Levy (2002:16) reiterates that it is possible for people to think that moral statements are
true relative to the feelings or opinions of individuals, or they are true relative to cultures of
different people. This is why it is believed that moral decisions are subjective, and morality is
just a matter of opinion. In the same light, cultural relativism holds that cultures set the
standards of moral truth. The implication of this assertion is that no expert or ethicist holds the
ace on an acceptable moral decision education or advice. It is the domain of each individual,
based on his reason, or the domain of different cultures based on their beliefs and values. The
advice given by an ethicist or expert is relative to his/her opinion and culture where he/she is
socialized. In other words, whatever he/she might have to offer as a professional advice might
not be in consonance with the feelings, opinions and cultures of others.

If cultural relativism is true, it means that the tag of a moral expert, consultant or an
ethicist might only be worn among those who share his/her feelings, opinions, and cultures.
Therefore, expert advice or education is limited to a specific boundary, its transcendence to another boundary may not be appropriate because of varying beliefs, cultures, and values among others. Is this true? If the answer is yes, what about other professions like law and medicine, where there are relative legal process and relative treatment of some illnesses? Does it mean that lawyers are relevant relative to the legal framework of his domain or culture? Or doctors relative to accepted treatment of some illnesses within his boundary?

Moral relativists, according to Levy (2002:22) believe that it is possible for opinions and standards of different cultures to conflict, where one and the same moral statement may be true relative to one standard and false relative to another. For this reason, clarification by an ethicist on such moral standard may not be useful because of the relative status of any moral issue. The acceptance of a standard or rejection of it rests with different cultures based on their belief systems and values. But contrary to this submission, Levy argues that, “The mere fact that relativism gives rise to such apparently paradoxical conclusion is not sufficient to explain the passions that surround the debate [for ethicist]” (2002:22).

In support of this view, I equally reject arguments against competence or professional acumen of an ethicist in moral debates based on the idea of relativism or individual intuition, reason or feeling. The basis for my rejection is that virtually all complex issues with respect to all facets of human endeavours are characterized by normative relative standards. Take for example, health care, where treatment of certain diseases varies with beliefs and cultures, still this does not jeopardize general acceptance of physician’s competence across all cultures and divide. Pluralism exists in healing and treatment systems of the entire world. Therefore, the fact that moral issues are relative does not threaten the existence of an expert who can clarify and engender reflection better than others based on his/her professional competence.

Baier (2001:253) argues that people think that reason enables us to think clearly about consequences or likely consequences of alternative actions and “… to foresee outcomes and avoid self-defeating policies”. She disregards this notion and sums up thus:

But “the ultimate ends of human actions can never, in any case, be accounted for by reason, but recommend themselves entirely to the sentiments and affections of mankind, without any dependence upon intellectual faculties” (Hume,1975:293).

Therefore, in addition to reason there is the need for knowledge on how to cultivate moral sentiment, and intellectual ability of few persons, like ethicists (who have reflective feeling
responses) is needed for the understanding of morality and moral cases. In line with this, Pence (1995:5) posits that good judgments require knowledge of complex concepts, general facts, and specifics of each case, and ability and willingness to balance different values. The argument here is that, beyond individual reason, there are other significant components necessary for solving moral problems. These components are no doubts learned rather than acquired through reason or socialization process; as such experts’ opinions are significant in mitigating complex ethical issues.

3.2 Distinctive Features of an Expert Ethicist

The need for experts to tackle moral quandaries of our time could not be over-emphasized. According to Baylis (2004), ethicists “speak truth to power” and if they are silent or unavailable when required, it could be troubling. What this means is that ethicist’s expertise is necessary in order to avert moral chaos that might simply be avoided. Marino (2001) equally opines that their training in moral theory renders them more virtuous than their clients, and they have extraordinary acumen in the dissection of moral problems. Crosthwaite (1995:363) gives a run down of the philosophical expertise that may be required of an expert ethicist -- skills, knowledge, and values -- for clarification and analysis of concepts and problems, and construction and assessment of arguments and viewpoints. She argues that in general, the knowledge component of philosophical expertise consists of:

- knowledge of philosophical problems, questions, positions and theories
  (e.g. ethical theories, theories of knowledge, views about human nature and society)
- knowledge of assumptions, consequences and criticisms of different positions or views
- knowledge of types of argument and likely problems (e.g., fallacies like false dichotomy or ambiguities of scope) (Crosthwaite, 1995:363).

It shows therefore, that a moral ethicist has a wider view and deep understanding of issues, which might aid reasoned argument and clear assessment of beliefs and claims. In addition to this, it is believed that specifically, a medical ethicist high points include mastery of historical, theoretical and methodological underpinnings of bioethics, command of academic literature, rigorous training in ethical reflection, analysis and argumentation (Zoloth-Dorfman & Rubin,
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Such ability equally assists in challenging and questioning doubtful assumptions, and it equally helps in generating solutions to moral questions and ethical problems. There is no doubt that these knowledge components of an ethicist might not be found comprehensively in other professionals touting themselves as professional ethicists as well, or those lay people who claim that technical moral prerogative is unfounded because each and everyone is endowed with such knowledge and capabilities.

While some argue that there are no specific professional standards that might be attributable to medical ethics profession, it is believed by others that absence of these professional standards is not really the major problem confronting the profession, but inadequate or lack of substantial and coherent idea of what even a properly educated medical ethicist might add to a difficult clinical situation, medical ethics debate and medical ethics committee’s discussion. According to Satel & Stolba (2001:37), the profession’s “core knowledge areas” and “core competencies” as documented by the American Societies for Bioethics and Humanities are: familiarity with subjects such as moral reasoning, health law, organization of the health care system, and engagement in “creative problem solving”, “listen well”, “communicate interest and respect” and “distinguish ethical dimensions of a case from other overlapping dimensions”.

The objection to this argument might be that all these core competencies of medical ethicists are not really outside the purview of medical doctors and other categories of professions that are familiar with medical ethics. While one might hold this argument to be true, it is equally desirable to be aware that general knowledge and interests of researchers and medical doctors in ethical issues is not sufficient for not deferring to professional medical ethicists. Familiarity with moral principles and maintenance of healthy interest in ethics is not a reason for overlooking or underestimating the professional integrity and competencies of trained ethicists.

It is opined that medical ethicists are not only masters of code-like theories and law-like principles, but they are architects of moral space within the health care setting, and mediators in conversations taking place within the same setting. Some physicians spoken to by Walker (www.questia.com), on the idea of moral expertise and their experiences with medical ethicists once remarked that, ethicists are unarguably useful, helpful, and encourage them on the consideration of the principles of autonomy and paternalism. They argue that personal and institutional pressures associated with medical practice make deference to professionals like ethicists, an important one because it allows one to feel more confident or more responsible in taking decisions.
Medical ethics experts are trained as social critics and analysts of processes, relationships, linguistic interactions, moral appeals, and ethical argumentation (Zoloth-Dorfman & Rubin, 1997:425). In other words, they are abreast with varying moral issues, how interwoven they are, and how to draw out differences, relationships in order to arrive at possible solution. Crosthwaite (1995:364) believes that moral experts are not only skillful in reasoning, analysis and knowledge of ethical theories, argumentation surrounding ethical issues and problems, but also, “a critically examined moral perspective from which some judgments on particular issues are likely to follow”. This is commonly found among the casuists who make an attempt to determine a correct response in a moral dilemma by drawing conclusions from different paradigms. They analyze ethical issues; support the analysis with reasoning and justification with the aid of intellectual and interpersonal facilitation that ground whatever advice or recommendation presented. Casuistry is a practical approach to morality, involving critical examination of different moral perspectives, using a case by case analysis in order to determine a correct response to a particular case.

From the foregoing, it is clear that professional ethicists or experts are harmed with sufficient traits that give them an edge over individuals assumed by critics to be qualified to do the job by virtue of mere feeling and reason. According to Dawson & Garrard (2004:420), it is true that no one knows our individual situations better than ourselves, that we are better judges of our different situations, but there are limits in specific instances where judgments are best passed by the third party. This is usually the case when “individual’s epistemic authority is in doubt”, for example, due to irrational fears, over estimation of research result, or what the authors called “misplaced sense of altruism”.

To me, this is a plausible reason for an expert ethicist, in the sense that assessment of ethical problem in a case of this magnitude lies beyond subjectivity and personal interest. The contribution of an ethicist to allay fears, doubts and anxieties of research subjects or clients has no connection with a direct benefit he/she stands to gain by doing so. He/she is not directly affected by such research, but he/she is just using his/her professional expertise and training to help or save others that might have dived deep in the moral seas.

Besides, other traits abound for the justification of experts’ role in moral reflection. The development of science, medicine and technology is described to be out pacing our moral sensibilities. Marino (2001) therefore, captures the expertise of ethicists in this way:

Scientists: may not be the best people to set the moral parameters of the technologies that they have invented. If you are looking for a person to
develop a protocol for the just distribution of organ donations, you do not want to ask someone in need of a transplant. One precept that people of different ethical persuasions agree to is the notion that fair judgment is best served by disinterested individuals. The very notion of the ethics expert is formed around the idea that in the professional ethicist we have someone who is both trained in ethical reasoning and relatively free of interest in the issue that he is charged with reasoning about.

I hold the view that it would be hard to reject the above submission, on the ground that interpretation, reconciliation, assessment of incomprehensible research information, and sorting out of conflicting perspectives, based on sound reason, form part of the core expertise of an ethicist. This is not to say that other people or professionals might not perform the same task, but the obvious thing is that this knowledge is specifically embedded in their interdisciplinary pedagogy.

Besides, Crosthwaite (1995:366) reiterates that outside public policy issue, it is increasingly expected that ethics committees evaluating health research and innovative treatment proposals and protocols should have access to the expertise of a philosophically trained ethicist. She contends that when engineering advice is needed, we consult accredited engineers, even if it’s possible to argue that someone outside that profession may possess the skills and knowledge required.

One may deduce from here that, the possibility that expert’s professional expertise may influence moral judgments in a different direction from those of ordinary societal members explains the significance of expert’s expertise contribution and involvement, in the discourse of practical ethical concerns. Therefore, society may need to seek professional ethicists or experts advice on moral issues based on their philosophical leaning and practical experience in the course of their training. According to Zoloth-Dorfman & Rubin (1997:429), an ethicist is like a navigator -- accustomed with the map, terrain, and moral complexities, and he/she directs desirability or otherwise of changing a course by the immediacy, temporality, and particularity of a given case, with just an ability to guide, rather than controlling the course. They sum up ethicist’s expertise thus: “…can offer direction, vision, and even warning about the implications of a chosen path, contributing the unique perspective and tools of her profession. She can use questions, arguments, and moral suasion” (p. 429).

The objection to this argument may lie in the opinion that these expertises may equally be acquired not only by an ethicist but by several other professionals within medical ethics.
committees. But the difference lies in the fact that mere fascination with ethics or deep interest in ethical issues, without requisite knowledge and appropriate training in philosophical inquiry and methodology does not make one a professional ethicist. Therefore, a superficial knowledge of a particular profession does not place one in the same pedestal with someone certified in the art and practice of such profession.

The necessity for expert consultation lies in what Crosthwaite (1995:370) describes as: the need to provide reasons as a basic ingredient in moral judgment. She argues that “moral judgment is a reasoned-governed activity… It is also fundamental to the idea of the possibility of moral expertise, and to any advocacy of a role for moral philosophy in such deliberation”. The point one needs to note here, is that there are professional ethicists with distinctive skills and knowledge, different from that of the general public when it comes to evaluation and reflection on complex moral issues. These experts use their experience and expertise to bear on deliberation, line of thinking, and point out the relevance of various components of morally problematic situations.

It is the duty of an ethicist, more than any other professional, to engender rational moral discourse. For example, to discover all values at stake and subject them to public discourse, and seek to be neutral as much as possible. According to Lauritzen (1994:157), impartiality has come to be identified as the hallmark of moral decision making in modern moral philosophy because of the influence of modern science, and the quest for invulnerability. That is, by inference, an ethicist must not be vulnerable and his/her integrity must not depend on events beyond his/her control. Stanley Hauerwas views on impartiality vis-à-vis the role of an ethicist is summed up this way:

At least partially under the inspiration of the scientific ideal of objectivity, contemporary ethical theory has tried to secure for moral judgments an objectivity that would free such judgments from the subjective beliefs, wants and stories of the agent who makes them. Just as science tries to insure objectivity by adhering to an explicitly disinterested method, so ethical theory tried to show that moral judgments, insofar as they can be considered true, must be the result of an impersonal rationality (1994:155).

Therefore, in my opinion, it is not impossible for an ethicist to maintain an impersonal and impartial position in a public moral discourse because his/her interests, decisions and judgments are in the consistency and force of rational argument. Ethicist detaches from
friends, family, and his/her own personal projects that might otherwise generate what Kant, calls “substantial moral conflict”. Kant maintains that when engaging in moral discourse, “…we must discount our particular attachments, say, to friends and family, then moral decision making is greatly simplified and the possibility of tragic conflict greatly reduced. Thus, just as impartiality was essential to the project of making moral judgment as rigorous as scientific judgment, so too is it essential in the quest for invulnerability” (Lauritzen, 1994:157).

The components of ethicist’s expertise that may guide in discourse of moral problems, as elaborated above, do not necessarily arrogate unto ethicist, power of judgment on what is right or wrong. At the same time, they do not abdicate individual’s responsibility to an ethicist; rather they set limits on what an ethicist could do. I do not support the argument that claiming to have an ethics expertise is synonymous with making authoritative decision on moral policies and actions, having an objective answer, impeding moral faculties of citizens, granting superior status to ethicist, trespassing the role of physicians etc., rather moral expert provides: options and alternative choices to target group or clients, ability to reflect, and provision of coherent justification for judgment among others.

3.3 Evaluation of Objections against Ethicist’s Expertise.

There are hordes of arguments against ethics expertise, in spite of the various expertise of an ethicist elaborated in the preceding section. For example, C.D Broad (1995:370) says: “It is no part of the business of moral philosophers to tell people what they ought or ought not to do…Moral philosophers, as such, have no special information not available to the general public about what is right and what is wrong”. In the same light, Scofield (2001) argues that ethicists should not arrogate unto themselves the role of evaluating and choosing the right course of action. He argues that doing so denies others the right to make their own judgments.

According to Baylis (2001), “Scofield contends that in the realm of opinion testimony about what ought to be done; ethicists are the equal of everyone else and should not be in a privileged position…” (pp. 240). This position fails to examine the distinctive traits of an ethicist in relation to non-experts’ contributions to moral debate. What is required is the understanding of the skills of an ethicist, and what he actually does in moral discourse.

Firstly, it is important to note that all consultations, recommendations and advice offered by an ethicist to committees, patients, families and physicians are not binding, but optional, depending on the parties who receive the recommendations to reject or accept them. An
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Secondly, the privileged position occupied by an ethicist, which separates him/her from being equal to every other person or a bystander is a direct result of his/her skills and ability to: call assumptions, guesses, beliefs and values into question through scrutiny and critical reflection. He/she also helps articulate, convey, communicate and express divergent positions on issues, with clarity; evaluate positions with respect to value at risks, especially present and future risks relating to ethical problem under discussion; and to defend fundamental values at risk, and propose steps for ethical problem-solving and consensus when it is possible to do so (Thomasma, 1991:138).

Therefore, Scofield’s position does not hold, based on the fact that decisions made by ethicists are not compulsory to be adopted on one hand, and the fact that more than a bystander, an ethicist has a powerful communicative, expressive and reflective ability.

While it is true that all human beings get socialized in a certain moral system during our upbringing, according to Brom (2005), the application of thick concepts we learned in real and imagined situations calls for an existence of moral knowledge in order to develop and systematize our moralities. Thus, while it is agreed that we might all be aware of what is wrong or right in different situations, I disagree that knowledge, skills and expertise required for systematized moral progress are common to everyone; rather, they fall perhaps, in the domain of the ethicist. The premise of this argument is based on requisite knowledge and specific training of an ethicist that qualify him/her more than those who lack such acquisition of knowledge.

Düwell (2005) misgivings against bioethics, and perhaps professional ethicist is the fact that bioethics is avoiding their normative judgments to be dependent on only one normative ethical theory, rather, they are dealing with moral problems without reference to philosophical foundation for their normative basic assumptions. One needs not disregard ethical reflection and judgment on normative issues to be premised on sound theoretical foundation, but theories in themselves are not sufficient to clear thorny moral paths without ability to clarify and analyze concepts and problems.

The above argument is corroborated by Brom’s position that we needn’t a theory of morality before we can speak of morality, but basically, we can’t rule out the necessity of theoretical reflection on morality to support and elaborate the implicit reflexivity of positive morality. He sums up as follows: “Finding a justified non-arbitrary criterion for deciding which moral demands are legitimate, does not necessarily imply searching for an abstract
theory” (Brom 2005:1-2). The task of an ethicist therefore, is to be reflective, present rational argument, and develop morality.

One philosophical tradition against the idea of expertise in ethics is that morality is based on feeling, and if you have sympathy for others, you will probably behave morally. They argue that since morality is based on feeling, the capacity which I either inherit and/or learn, what then is the use for ethics expert? Hume plays up the role of feeling in moral judgment. According to Baier (2001:252), Hume claims that: “...morality rests ultimately on sentiment, on a special motivating feeling we come to have once we have exercised our capacity for sympathy with others’ feelings, and also learned to overcome the emotional conflicts which arise in sympathetic person when the wants clash, or when one’s own wants clash with those of one’s fellows”.

The above argument portrays that an ethicist may have feeling, sentiment and be sympathetic, yet it doesn’t affect their impartial role or threatens their expertise. Baier supports a morality premised on authority of feeling rather than that of sovereign individual reason. Morality, on Hume’s account is a product of fruitful search for ways and means sympathetic persons gets rid of contradictions in their own and their fellows’ desires and needs. According to Hume, what is important is “the correction of sentiment’, where what corrects it will be contrary sentiments, plus the cognitive-cum-passionate drive to minimize conflict both between and within persons” (Baier 2001:253). Ethicist’s expertise, therefore, plays a significant role in diffusing moral tension that rears its ugly head between individuals, persons, and groups when sentiments take the driver’s seat in complex moral debate.

From Baier’s opinion, Hume tries to see an ethicist as one who retreats from his or her “private and particular situation” to achieve an impartial perspective. Baier concludes that by abstracting from particular situations and personal sentiments, the agent is affected only by sentiments of humanity (2001:257). Therefore, I argue that reducing morality to be entirely dependent on the particular feelings of individuals as claimed by the initial philosophical tradition above is unarguably inaccurate. This is so, because ability of an ethicist to remain invulnerable, and resolve not to be basking and enmeshed in ego boosting, personal sentiments, may be explained in the light of the expertise of an ethicist, incorporated in his/her professional code of conduct.

Professional ethicist’s expertise is also faulted on the ground that in ethics, no one can claim to be objective. According to Baier, Hume as a philosopher maintained that no absolute certainty exists, and we do not know anything with absolute certainty and truth is not achievable in many areas of inquiry, including ethics. This to me, is a plausible proposition
because moral decision making exercise is beyond fruitless search for objective answer, rather it is a product of exhibiting distinctive skill and knowledge in an open dialogue, engagement and interaction with one another.

To Hume therefore, moral judgment is beyond exclusive appeal to facts, objective knowledge and truth. It is true that ethics is based on value judgment, at the same time it is indefensible to rule out values even in medicine and other sciences. Pellegrino & Thomasma (1999:127) argue that though medicine has a scientific character, it is also a moral activity because medical decisions are dependent upon value judgments and for the good of the patients. Ethical issues are products of conflicting societal and personal values, and when appeal to measurable data is futile in order to determine the right course of an action, appeals are made to values and the role an ethicist might play here is quiet significant.

In support of this argument, Baylis (2001) contends that debunking the role of moral experts based on the fact that ethics is not objective or there is no moral truth is baseless. He stresses that moral truth is not a necessary condition for the existence of moral expertise.

... There are many areas in which we do not expect "truth" from those with expertise; rather, we expect knowledgeable answers along with good reasons for those answers. Why expect more of those working in ethics? In ethics, knowledge of the major ethical theories forms a basis for, or rather, underlies expertise in that someone with such knowledge could draw upon it when confronted with an ethical dilemma. When making moral decision, however, a person with moral expertise relies upon his/her moral judgment, not upon some notion of moral truth (pp. 240).

He reiterates that expectations from experts should not be truth, but knowledgeable answers backed with good reasons. This position is worthy because it is not only in the field of ethics in which claims to expertise do not rely on objective knowledge, professions such as architecture, economics, genetic counseling and legal experts also have no claims to objective knowledge. Moral experts are imbued with skills required for acquiring, retaining, organizing and exploiting ethical knowledge in a way to contribute to the framing and resolving complex ethical problems, rather than preoccupation with chasing moral truth.

Marino argues that ethicist’s expertise is questionable because ethics experts often disagree with one another, “If ethics constitutes a body of knowledge, then you might expect ethics experts to offer similar responses to the same straightforward problem. There is,
however, much disparity in expert opinion in ethics” (Marino 2001:11). His conclusion that their disagreement on a relatively simple problem makes no difference between experts and non-experts alike is faulty. Expert’s disparity on issues is not peculiar to ethics; this is a ubiquitous professional phenomenon, even in science. Disagreement, therefore, is an avenue for judgment to be a subject of open debate, substantiated, refined, and perhaps be resolved.

In defense of diversity of expert opinion, Mackie(2001:27) argues that significant differences in moral belief and judgment is better explained by distinguishing relativism of judgments from relativism of standards. I give an example to illustrate what he means by this. When ethicists differ on whether a depressed septuagenarian, with terminal cancer, who requested all treatments to be stopped should be allowed or not, they may be clearly differed in their judgments, but they do not have different moral standards of autonomy or different goals of respecting patient’s autonomy. Hence, it is plausible to argue that if relativism of judgments is true, there may not be a relativism of standards.

3.4 Conclusion

This chapter succeeds in cataloguing the nature of authority and expertise possessed by a medical ethicist to support relevance of his/her inclusion in Medical Ethics Committees, and to establish him/herself as a professional, expert and consultant in the field of medical ethics. Two models were examined in relation to nature and authority of a medical ethicist. A medical model was objected due to its parochial scope and limitation of ethical authority to only health workers. A multidisciplinary or feeder discipline model was accepted because of its comprehensive scope and clear definition of who an ethicist should be.

It is equally discovered that the notions of relativism and reason are clear impediments against professional claim to medical ethics and ethics expertise. These concepts threaten idea of expertise knowledge in medical ethics because of the relative status of morality, and individual’s responsibility for his moral choice without abdicating it to anyone. Different positions counter absolute use of reason and stark emphasis of relativism in moral issues, and some positions favor ethicist’s advice based on his/her skills and training.

It could be inferred from above that, huge criticisms against experts’ intervention on moral issues do not necessarily justify that some expertise -- even if it is limited -- may not be found in ethicists, and as such, when it comes to moral issues, they are not equal in skill, knowledge and ability with any other individual. While it is not claimed that this expertise is
sufficient in dealing with moral issues, I defend the fact that it may be useful to guide individuals and groups in reflecting and perhaps make positive moral choices.
Chapter 4

4.0 Introduction

In the last chapter, basic and distinctive features that distinguish an ethicist from other group of professionals and laypersons were highlighted. It was shown that the idea of relativism, moral pluralism, absence of moral truth and individual’s ability to reason ethically, among many other factors, stood against general acceptability of the expertise of an ethicist. The objection to professionalism in ethics is not sufficient to obliterate the role of an ethicist in issues relating to moral conflicts of our time. Most of the issues characterizing our existence are subject to individual’s choice, relativism, and application of reason. For instance, if an ethicist is rejected based on the fact that ethics is not an objective discipline, or an ethicist’s recommendation is value-laden, many other professions -- medicine, law, economics, e.t.c -- are guilty of appealing to values in their judgments as well.

This chapter focuses on reasons behind normative proposals for the significance of a medical ethicist as individual consultant, expert, and a desirable, unavoidable member in medical ethics debates, and in any Medical Ethics Committee. These proposals are based on the expertise and traits inherent in medical ethicist, which qualify him/her as a fit for such enviable role, and his/her inclusion in a Medical Ethics Committee might not be over-emphasized. In the other part of the chapter, I would highlight factors militating against medical ethicist’s professional status and acceptance by critics, anomalies within the rank and file of medical ethicists themselves, and what the future holds for the discipline of ethics as a profession and ethicists as experts in modern moral space.

4.1 Reasons behind Normative Proposals for the significance of Medical Ethicists in Medical Ethics Debate.

I have argued extensively in the preceding chapters for the significance, roles and functions of a medical ethicist as an expert, consultant, or a desirable member of any Medical Ethics Committee at the institutional level. I gave a run down of the skills, knowledge base, training, theoretical and philosophical foundation upon which his/her expertise could be founded. It is based on these that an ethicist is distinguished from a layperson and other related professionals -- nurses, physicians and lawyers, etc. -- and I justified his/her inclusion in the group of other professionals when complex medical issues are to be deliberated upon by a committee.
Substantial evidences and arguments are put forward by the apologists of medical ethics as a discipline, and medical ethicists’ professional mandate. They argue that complexities that surround medical technology’s advancements, and personal and institutional pressures associated with medical practice make deference to professionals like medical ethicists, an unavoidable one. In this sense, it allows different parties involved in ethical discourse to build more confidence and feel more responsible in taking decisions.

Based on the foregoing, I draw the following reasons to support my normative proposals for the desirability of a medical ethicist in a moral debate relating to medical issues. I will elaborate on some of the critical opinions and comments about professional medical ethicists that we have already read in the previous chapters:

- Some critics argue that different professionals like physicians, nurses and lawyers are suitable members of a Medical Ethics Committee, and with other laypersons, theologians, politicians etc., moral reflection, proper advice, and appropriate recommendation might be attainable without necessarily including an ethicist specifically on the committee.

I disagree with this belief because the role of an ethicist is likened to the role of a coach for a football team. A football team is a blend of individuals with skills, professional status, and adequate football knowledge. In spite of this, the coordination of these different skills, knowledge, and professional integrity lies in a coach, who reads the game and uses his distinctive knowledge to direct the tempo of the game. An ethicist functions just like this. He/she gives advice and recommendations based on different values and beliefs which he/she critically analyses. Like the players in a football team, it is up to policy makers or research subjects to whom the advice of an ethicist is targeted, either to accept or reject it. These decisions are never binding; it is open to choice, based on individual’s initiatives and desires due to the concept of sovereignty.

- Some critics also claim that ethical decisions are individuals’ responsibility, we are our moral legislators and we need no specialist to guide our moral choice, as that would amount to infringing and impinging on the right and freedom of individuals to choose what they desire, as long as it affects no one.
This is as good as saying that a child born genius needs no further tutelage by any teacher! The child’s ingenuity is properly harnessed by a teacher who guides him to his optimal level. A direction from a professor is just a guide towards a particular objective, one may have an overriding direction other than that of the professor, but the professor has reinforced one’s choice of eventual direction. Therefore, ethicists are useful as consultants, with expertise that might guide individuals in making choices in volatile moral issues.

- Some equally argued that ethicists state what is obvious, i.e. there is nothing new that ethicists have to offer that has not been known to others. As such, ethicists claim to have distinctive skills, or their arrogation of ethical expertise to themselves may be untenable. Theologians, clergymen, physicians, nurses and scientists are in the same position that an ethicists claim to be their professional domain.

The case above is far from being totally true. It is partially true because all other professionals mentioned in the argument only have peripheral knowledge of what medical ethics is all about. Some of them are merely conversant and interested in ethical issues arising from medical situations. I have two examples to back my reason for the relevance of medical ethicist’s involvement in medical ethics debate.

The first is the question about the field of competence and responsibility of a nurse and a physician. An experienced nurse may be more knowledgeable and skillful than a newly qualified physician due to the nurse’s experience on the job and interaction with a number of old time and skillful physicians. Nevertheless, the quality of patient’s diagnosis and prognosis is a direct responsibility of a physician.

Secondly, we can examine the competence of a building and structural engineer and that of a mason or bricklayer. It is a possibility that a mason may exhibit high level competence than a structural engineer, but no one trusts building of a giant edifice in the care of a mason without supervision or direction of a competent structural and building engineer.

Therefore, equating the competence (in ethics) of all these professionals -- physicians, nurses, theologians, clergymen, etc. -- with medical ethicists is like begging the question. They have deep and thorough understanding of multidisciplinary disciplines that aid and buttress the professional status of medical ethics.

- Critics have also opined that individual reason, and not necessarily ethics expert’s clarification is enough in moral judgment and decision-making. The relativism in
ethics and absence of objective truth do not support parading medical ethics as a professional discipline. Expertise in the field therefore might only arouse partiality and imposition of others’ moral agenda.

I am still convinced that medical ethicists have significant roles to play either in medical ethics committee or as consultants, and in decision-making relating to medical issue. It is not only in ethics that objective truth is debatable, and objective truth is not a necessary condition for a professional ethics. It should also be noted that it is not all individuals that can reason without assistance to clarify issues affecting their lives. We can take examples of incompetent adults and children who may be approached to take part in series of trials or as research subjects. Ethicist’s skills of critical evaluation of cases may engender subtle clarifications on moral issues affecting these incompetent people. It is possible for an ethicist to be impartial in the advice and recommendations given for two clear reasons. First, an ethicist is not directly affected by the conditions of the subjects in these cases, and second, as a professional, he/she is driven and motivated by creating public utility rather than pursuing his/her personal moral agenda. Therefore, an ethicist is a desirable member in a forum where ethical issues are being dealt with.

It is important to add at this juncture that before these reasons behind normative proposals for the desirability of a medical ethicist might be a reality, a lot has to be done by medical ethicists to rectify some of the anomalies that may obscure or hinder the profession from attaining its full potentiality. Some of these issues that cast doubts about the professional status of medical ethics and ethicists’ expert knowledge are discussed below.

Therefore, for ethics experts to remain as forces to be reckoned with, maintain their professional integrity and be accepted in the scheme of things, there is the need for the profession to carve a niche for itself like all other professions that have stood a test of time. The argument against the profession is a necessary condition for it to surge forward, through critical evaluation of its practice, in order to ensure uniformity within the rank and file of its members.

4.2 The future of Experts in Moral Debates and Medical Ethics Issues

It is crucial to state at this juncture that if medical ethicists are to sustain their role in medical ethics debate, and secure the profession of medical ethics for the future, arguments
against medical ethicist’s acquisition of moral expertise are necessary. This is vital in order to evaluate, constantly, shortcomings in medical ethics practice, and work towards its positive development in the future. The growth of ethics as a discipline, and specifically, the growth, maturity and acceptance of medical ethics is a thing of the future. How it matures into the future is crucial amidst volumes of criticisms and arguments against it. This supports Crosthwaite’s (1995:365) opinion which holds that awareness of critiques would improve the skill base of the ethicists and foster alertness to the way in which background theories, assumptions and interests could lead to the framing of questions, and to the effect of such frames in directing and circumscribing debate and the possibility of solutions.

The future of ethicist’s expertise on moral issues depends largely on charting a clear course for ethicists, for instance, there is an urgent need to determine criteria to be followed before a legitimate claim might be made to be a professional ethicist. Like any other established profession, the criteria might be worked out by the Guild of Professional Medical Ethicists.

According to Loewy and Loewy (2005:79-80), if ethics failed to become a profession, it has to a large extent failed in its social responsibility. They argue that it is pertinent for ethics as a discipline to define itself, set criteria for membership in the profession, police itself and -- above all -- meets its social responsibility to become a profession meriting that name. This goes with professional integrity as well. What I mean by this is that when there are specific criteria for membership and calling into the profession, it injects some form of sanity into the profession and guard against loss of professional integrity. Integrity in this case, refers to a situation where professional ethicists have a set of overarching common goals, which goes with the willingness of the members of the profession to discuss peacefully, mutually, within an established framework, and above all tolerate their individual differences, views and values. It also includes giving up “some of their private aims for the general social good” (Loewy & Loewy, 2005:75).

The emphasis here is that those who are certified according to an established standard are expected to have labels of professional ethicists. According to Cummins (2002:20), the need for credentials or licensing is a function of growing desire to disqualify charlatans and to ensure recognition by other professionals in health care. The desirability for a professional standing is justified because of ethicists increased interactions with other licensed professionals. Therefore, certification reinforces their expertise in health care ethics, consultation, and ability to make fruitful changes in the deliberation of Medical Ethics Committees. This also legitimizes their claims as advisors in cases that arise in medical decision-making process.
If members are not filtered like in law, medicine and engineering, there is the likelihood that different individuals might claim to be ethicists, and as such it jeopardizes professional integrity and allows even quacks -- those who have little or no knowledge of traditional ethical theory -- to give moral advice and recommendation. Like I said earlier on, no one is precluded to have interest in medical ethics, but such interest is not a claim or license to professionalism without proper criteria -- tools, methods and perspectives -- that qualify one as a professional medical ethicist. Medical ethics should not be seen as an extension of an individual’s personal ethics. There is the need to realize that specialized knowledge and skills are essential in dealing ethically with complex medical decisions. To be assigned the role of a medical ethicist, therefore, goes beyond an assumption that one is merely interested or gets fascinated with issues relating to medical ethics. The use of such ability is not enough as a guide in medical ethics decision-making, but thorough knowledge is quiet essential.

It is therefore wrong to assume that, “[medical] ethics courses are nothing more than a series of anecdotes or intuitions that ethical judgments are simply matters of individual opinion, that they aren’t scientific, that they aren’t verifiable” (Bowie, 1991:22). Those who express this opinion do so, due to lack of systematized and codified requisite skill base for ethicists, and this is why the field of medical ethics has been polluted by what Cohen (1992a:8) termed as “naive newcomers” who lacked deep understanding of philosophical and ethical theories. These newcomers are imbued with diverse knowledge and skills from different disciplines, and as such ethical decision making is being investigated from philosophical, psychological, sociological and theological perspectives (Fraedrich, 1991:8), thereby leading to absence of an agreed body of knowledge that defines medical ethics as a field unto itself (Dean, 1997:1638). The need therefore arises in the future, to delineate and define what constitutes professional medical ethics, in line with what is obtainable among many other professions before it.

**4.3 Does a Medical Ethicist possess what it takes to be a Professional?**

There are certain professional traits expected to be possessed before a group of people could come together under an umbrella of a profession. The future of professional medical ethicists and ethics lies in working to attain fully these traits that characterize a profession. How medical ethicists and other ethicists alike would realize this objective is another factor that needs consideration amidst several other obstacles that might stand in their ways.
Some of these traits are documented by two authors; the first of these authors are, Loewy & Loewy. They argue that the following criteria should be met before occupations must be called “professions”: have a moral and not a technical end, i.e. the good of those it serves is paramount than the quality of product it produces. All professions must serve a public good (public utility) and not just a cluster of individuals discussing a subject area; members must be knowledgeable in a number of prescribed subject areas. It must have a body of theoretical underpinnings and formal mechanisms for addressing the questions and advancing the state-of-the-art in its field; it must have established criteria which all future members claiming professional status must fulfill. Besides, it must ensure that future members keep current and maintain a certain level of competence; and it must be self-policing (Loewy & Loewy, 2005:76-77). The second author documents somewhat similar, but in a different version. These are: specialized knowledge, lengthy training, service orientation, autonomy, professional dominance, a vocation or calling, and professional mystery or mystique (Cummins, 2002:24).

While it could be argued that medical ethicists have accumulated a common body of knowledge such as ethical theories, principles, and facilitation techniques, including landmark court cases, there is still a lot to do in the area of period of training. It is not all medical ethicists that have graduate and postgraduate education and training, some are half-baked (without cross-disciplinary knowledge) and there is no compulsion yet for them to update their knowledge. The future now lies in ensuring that those who are informally trained or embarked on self-study are made to update their knowledge to keep pace with the requirement of a professional standard.

Some who argue to be medical ethicists are physicians who know little about ethics outside what they think or feel are instinctively right or wrong. Inadequate comprehension of the subject matter renders advice or recommendation that goes with it a little bit useful for the subjects who are to benefit from such advice. It is imperative, therefore, for the profession to ensure that its members are uniformly knowledgeable (with carefully drawn curriculum) in cogent interdisciplinary areas. Such areas are: physiology and disease process; familiarity with how medicine works; familiarity with history, language and methodology of philosophy in general, and ethics in particular. Added to these are: knowledge about sociology of medicine and some anthropology, in order to be able to distinguish the meaning of health, diseases and cure in different cultures; knowledge of law as it pertains to medicine; and above all, understand the economic and cultural suffering of their fellowman (Loewy & Loewy, 2005:77-78).
The objection to this line drawn by Loewy and Loewy might lie in the strict sense in which the discipline is defined, and perhaps, the fact that very few medical ethicists might meet these criteria. These criteria are necessary in order to do the job right. Some bioethicists might contend that they also function as medical ethicists and possibility or desirability of the definition might be questionable. Nevertheless, it needs to be clarified that every profession has criteria that members are expected to adhere to strictly, and non-compliance to such criteria leads to rejection into the professional guild. Once a curriculum is set, and criteria for medical ethics are well defined, the onus lies on all those who are genuinely interested in doing medical ethics to conform to rules without bias or prejudice to anyone.

The profession undoubtedly, meets the criteria of service orientation because it is not intended to be profit driven, but to elicit common good, through service to patients, clients and other groups who seek advice of its members. The area where the profession needs to make amends in order to put its feet on solid foundation is the area of professional autonomy. The autonomy is still far-fetched as there is no specific regulation of entry into the profession by setting standard of education and training, and control of those who can practice. Professional autonomy is an essential trait medical ethicists need to work on to secure the future of the profession. This might be a difficult task as long as ethics is conceived as everybody’s responsibility, and individual’s freedom to choose in-between different alternatives.

Also medical ethics is yet to be professionally dominant; rather it acts as a sub-specialty either in medicine or philosophy with their conflicting perspectives. Efforts therefore should be geared towards ensuring that medical ethics is professionally dominant with its own clear paradigms in the future, without a particular discipline hijacking its control so that it won’t remain a sub or mere appendage of other disciplines. Medical ethics identity and status need to be built firmly, through acquisition of a “…distinct mode of thinking and a unique perspective” by integrating the different disciplines that form its core into “…a new creation, with an agreed upon set of skills, standards, education, training and practices” (Cummins, 2002:25).

Lastly, it is crucial for the profession to clear doubts about what they do, and how they do it, for laypersons to see how they make a difference. The difficulty underlying this has to do with the general notion or belief that doing ethics is the domain of everyone. The profession should endeavor to clarify that it is not the duty of its members to make moral decisions for anyone, group or committees, but rather to facilitate moral discussions, debates, and to interpret participants’ positions to each other, to discern the values at stake, and to assist
others in making medical moral decisions. These functions could be expressed as what Cummins (2002:25) describes as the role of “demystifying medical authority”.

From the foregoing, it is quiet necessary to separate the wheat from the chaff because if moral judgment is reduced to individual personal business, society may be risking a journey into moral chaos. Therefore, in addition to all suggestions made to establish strong base for a professional medical ethics and recognition of the expertise of medical ethicists, an acceptance of Majumder (2005) criteria for determining the fit between the expertise and the issues in the particular case, by vetting expert’s “knowledge, skill, experience, or education” is a necessary condition (pp. 264). Equally, there should be a constant review of professional credentials, professional experience, and scholarly publications.

4.4 Other preconditions for Medical Ethicist’s Professional recognition.

As a growing profession, medical ethics should guard jealously against its professional decay and rejection by its critics. Some necessary preconditions for medical ethics professional recognition include; devising means of forging consensus on complex moral issues; protecting objective judgment of members; and defending normative claims and positions in order to develop understanding on moral disagreement.

Doing so may foster fruitful debates among professional ethicists with plural values. In other words, where a particular moral case elicits divergent views among ethicists -- such as conflicting standards of morality and conflicting judgments -- we still need to live together amidst these moral diversities that characterize our everyday life. According to Pence, people will continue to disagree with us if we feel that our own beliefs and judgments about moral issues are the best and public adoption of:

.. an attitude of complete certainty of our own ideas can make us seem moralistic, arrogant, prejudiced and closed-minded. Moral pluralism, on the other hand, gives us a chance to demonstrate, rather than simply announce, the value of our ideas; also, it gives us a chance to recognize what is valuable in other people’s ideas (1995:4).
By inference, establishment of ways and means of forging consensus with respect to volatile moral issues among qualified ethicists may be one of the ways forward to curb rigid views and possibility of flexibility to move discussion in the right direction. It is impossible for all ethicists to have one all-encompassing view or value. What is important in making good judgment is what Pence (1995:5) describes as, “the knowledge of complex concepts, general facts, and specifics of each case, coupled with ability and willingness to balance different values”. This position supports Crosthwaite’s perspective when she says that no judgment should be fixed, it could be altered by information which may affect individual assessment of a case. Judgment could change if genuine or valid reasons were offered to revise individual basic moral framework.

It is therefore necessary for ethicists to cultivate habit of sharing ideas and information rather than maintaining their individual dominant views. Also, habit of imposing individual’s views and values on an issue on other people, may tantamount to violation of their rights, and perhaps, may deepen the problem to be solved. Therefore, absorption of different perspectives, views, values and beliefs, leads to flexibility and adaptation to changes, without absolute commitment to one insight, theory or a rigid view.

There is also the need to evolve means of resolving moral disagreements which forms the premise of attack from critics. Ethicists need to be pragmatic and practical in their approach since moral pluralism may lead to moral disagreement. A way out of probable disagreement that may be consequent upon moral pluralism is summed up by Pence thus:

Not all of us have to agree on everything in order to agree on one particular thing. We can take specific cases one at a time; within each case, we can take specific arguments one at a time; and within each argument, we can sometimes even take specific premises one at a time…Moral reflection is what allows us to accept or reject each premise of an argument; it is what allows us to find a good answer in a specific case…if the premises we accept or reject, and the decisions we make in specific cases, vary as we gain more knowledge and experience in life;… our decisions change as a result of the process of moral reflection itself (1995:5-6).

If the above approach to moral disagreement could be adhered to in the process of moral discourse or assessment, the argument of critics that given for instance eleven ethicists a problem to solve on moral issues, they are unlikely to come to terms with one another, may
not be tenable or obvious any longer. According to MacIntyre, there are other additional five ways of solving moral disagreements, these are: obtaining objective information; providing definitional clarity; adopting a code; using examples and counter examples; and analyzing arguments (2001:39-42). Each of them is discussed in turn in order to expatiate on the significance of trade-offs in divergent values and beliefs, so as to pave the way for moral agreement and resolution among medical ethicists.

4.4.1 Obtaining Objective Information

MacIntyre (2001:39) notes that moral disagreements are less fuelled by differences over moral principles, or interpretation and application of these principles, but rather, he maintains that moral disagreements are more of lack of massive factual evidence, other than differences over theories and principles. He reiterates that differences in factual belief -- based on cultural relativism -- on issues of afterlife or the harm that would be produced by some preconceived action may generate apparent moral disagreements. At the same time, he argues that on the debate surrounding capital punishment as a form of effective deterrence to crime, factual issue -- though not all disputes about capital punishment are factual ones -- and not principle is the premise on which the debate is centered.

What MacIntyre opines here is one of those elements professional medical ethicists should always strive for, and medical ethics as a professional discipline needs to look into the issue of gathering objective facts, in addition to the use of theories and principles. If all medical ethicists have it as a goal to be more concerned with obtaining factual evidence in various cases, and try to present this in situations where there are differences in cultures and beliefs, rather than emphasizing moral rules, principles and theories, it is possible to allay fears surrounding moral disagreements either between cultures or among ethicists themselves.

MacIntyre (2001:39) also affirms that possible dangers to the general public involved in certain kinds of medical and scientific research, such as research on human intelligence, cloning, and fluoridation, among others, are issues and controversies that have to do with facts and values. He argues that controversies on whether there should be a compulsory screening for AIDS are centered on factual claims about how the human immunodeficiency virus (HIV) is transmitted, the extent of what could be learned from screening, number of persons threatened by AIDS, and the role of sex education in successful contributing to safe sex practices.
Therefore, it is worthy of note that procuring objective factual information is vital to avoid moral disagreement that threatens the existence and practice of professional medical ethics. The fact that cultures, values and norms vary in-between societies does not warrant that disagreement is not possible to avoid. While it is not in all cases that facts may bring moral disagreements to a halt, nevertheless when objective facts are marshaled on different sides of cases, it is possible to ease moral disagreements.

4.4.2 Providing Definitional Clarity

MacIntyre (2001:39) affirms that controversies among ethicists are a direct result of lack of definitional agreement over language used by disputing parties. He cites an example of the controversies over the morality of euthanasia which are deepened and fierce due to usage of different senses of the term “euthanasia” and heavy investment of the parties in their particular definitions. While one party equates euthanasia with mercy killing, other party may equate it with voluntarily elected natural death, while others hold that euthanasia by definition is nonvoluntary mercy killing.

The point raised here is that terminological problem and differing definitions of a case, is the bane of moral agreement among ethicists. For instance, lack of definitional clarity in the case of euthanasia, as enunciated above by different parties will always result in controversies and moral disagreement, and this renders it doubtful if the parties are actually discussing the same case or problem. Moral disagreements over moral problems characterize our existence as human, and we are often despair of reaching agreement on complex moral issues due to popular aphorisms that morality is a matter of taste, that beliefs are ultimately arbitrary, and that there is no neutral standpoint from which to evaluate disagreements (Beauchamp, 2001:22).

It is not out of place to think that cultural values’ differences may not allow for moral agreement, because one culture’s values do not govern the conduct of others. For instance, a tribal customs at a particular locality requires as an obligation the death of aging parents by their children, most especially when they are old and incapable of supporting themselves by their labour. This is considered as an act of benevolence, not an act of cruelty or killing. But persons reared in a different culture may not subscribe to this attitude, and it may mean different thing to such persons entirely. This shows that moral rightness or wrongness is relative to beliefs, values and cultures, and as such application of universal moral standards to all persons at all times may not be possible.
For this reason, MacIntyre (2001:40) concludes that there may be no agreed-point of contention in some controversial cases, because conceptual assumptions of parties may differ. This is true because, it may be difficult to have the same views on the same case; and parties to a particular case have tendencies to address the case separately, but what they ought to do is to develop a conceptual clarity, upon which an agreement may be founded. Although there is no guarantee or assurance that a dispute, or a moral problem will be settled when clear conceptual definitions have been worked out, nevertheless, it can help in advancing discussion of the issues.

4.4.3 Adoption of a Professional Code

According to MacIntyre (2001:40) resolution of moral problems could be facilitated if disagreeing members work out an agreement on a common set of moral guidelines, such as a professional code of ethics. Members of medical ethics profession should not give up until a professional code of ethics is fashioned out in order to harmonize starkly different moral point of views, ease moral tensions among members, and convert deep divisions on moral principles to a uniform one.

MacIntyre (2001:40) states that various forms of discussions, meetings, deliberations and negotiations are useful to the adoption of a new or changed moral framework that could serve as a common basis for discussion and judgment. This idea is a plausible one because rigid point of view hold by different parties in a moral discourse might not provide an avenue for any acceptable resolution. Therefore, when parties with unified moral principles -- based on flexibility that results in a code of ethics -- meet to discuss a moral problem, the resolution to such moral conflict may not be far-fetched.

MacIntyre gives an example found in United States of America to buttress his assertion on the need for adopting a professional code of ethics as a way forward to resolve moral conflict. He states that a commission at one time in US was appointed to study ethical issues in research involving human subjects, and at the start of its deliberation, the Commission adopted a unanimous, and common framework of moral principles that provided general background for deliberations. The commissioners came up with three moral principles: “respect for persons, beneficence, and justice” (2001:40). It is argued that this common framework of moral principles eased the discussion of the controversies the members of the commission addressed and led to unanimous decisions and agreement that might not have been possible otherwise.
So, if professional medical ethics is desirous in solving disagreements polarizing its rank and file, like every other profession, there should be a code of medical ethics to give guidance, shed light in a circumstance of uncertainty, disputes and in controversial moral issues.

4.4.4 Use of Examples and Counterexamples to Justify Positions.

The fourth means of averting moral disagreements among ethicists, as discussed by MacIntyre (2001:40), is that members should cultivate a habit of using examples and counterexamples in order to make points clear in cases, and to justify their different positions. In the case of the commission discussed earlier, the use of examples and counterexamples assisted them to resolve the issue concerning the level of risk that could be justifiably permitted in scientific research involving children as subjects, when no therapeutic benefits is offered to the child.

At first, the Commission in the example accepted the view that only procedure involving low or minimal risk -- i.e. the level of risk present in standard medical examinations of patients -- could be justified in the case of children. But with the aid of more massive examples, it was discovered that “…significant diagnostic, therapeutic, and preventive advances in medicine might not have occurred if procedures that posed a higher level of risk had not been employed” (MacIntyre, 2001:41). The revelation here is that, when ethicists are considering a case of moral dilemma, examples and counterexamples of previous and similar cases could help in re-shaping of views and moral principles.

MacIntyre (2001:41) reiterates that majority of the Commission members in the last example, abandoned their original view that did not support nontherapeutic research that presents more than minimal risk, and they now accepted the position that higher level of risk can be justified by the benefits provided to other children, most especially when terminally ill children are used as research subjects in the hope that such research would serve as a learning process about the disease and it will eventually help other children, now or in the future.

No doubt, a consensus on this issue among the members results in the resolution on the larger controversy about the involvement of children as research subjects. Therefore, using examples and counter examples by medical ethicists is another way of resolving moral intricacies. This is plausible because citing of examples and counter examples may encourage jettisoning of dominant and prevailing opinion for a more justifiable one, with wider benefits for the target group.
4.4.5 Analysis of different Arguments.

The fifth means of diffusing tensions surrounding moral disagreements put forward by MacIntyre (2001:41) is the most common methods of philosophical inquiry. This has to do with exposition of the inadequacies, gaps, fallacies, and unexpected consequences of an argument. He argues that by pointing out incoherence in an argument, it renders such argument to be a subject of alteration, and this is the same when the unexpected consequences of a person’s position are exposed.

It is necessary that when opinions of ethicists have unintended implications, or when their arguments implicitly provide reasons that are contradictory to acceptable standard, then we modify or alter such opinions or arguments. The point emphasized here is that inability of an ethicist to defend a moral argument that leads to an unacceptable and an unanticipated conclusion should lead to a change in that moral argument, and in the process of doing this, the distance between the parties who were initially in disagreement might be closed.

Therefore, medical ethicists should be prepared to engage in critical analysis of their different arguments on moral issues in order to expose inherent inadequacies, contradictions, gaps and fallacies embedded in the arguments. By doing this, every participant in the discussion is contributing to build a virile foundation for professional medical ethics. When an ethicist does not consider his own argument as dominant and unamenable, then the stage is set for public acceptance of ethicists’ views and opinions on moral issues, and criticisms against their profession may also wane.

4.5 Conclusion

This chapter justifies medical ethicist’s role in medical ethics debate, and reasons provided to buttress the normative proposals are located in the skills, knowledge, training, theoretical and philosophical background of an ethicist. It is argued that a medical ethicist’s competence as a professional depends largely on how the profession approaches its future. In other words, for a just claim to be upheld as a professional medical ethicist, capable of guiding our moral decisions, in the future, the profession should be prepared to have established criteria for members, promote members’ professional integrity based on common goals and promotion of public utility. This would accord professional medical ethicists a sort of legitimacy as advisors, and those who can guide us in making moral choices.
In addition to the above, the profession should strive for meeting standards of a profession such as: specialized knowledge acquisition, specific training period, service orientation, professional autonomy, professional dominance, a vocation or calling, and a professional mystery. Failure to attain this objective may constitute a cog in the wheel of progress for the profession in the future.

In the same vein, all medical ethicists should endeavor to strive towards, at least, minimal consensus on volatile ethical issues in medicine, protect objective judgments of other members, and defend normative claims made by members on diverse cases that may be presented before them. Some of the means towards consensus on moral disagreements that might be employed by ethicists are: obtaining objective information; providing definitional clarity; adopting a professional code; using examples and counter examples; and analyzing different competing arguments.

Lastly, it is important to note that all these preconditions and means discussed may not be applicable to all moral issues where medical ethicists are to come up with resolutions, recommendations, or offer pieces of advice. We have to accept that some moral disagreements may not be equally resolved through these various means presented, and I made no claim to the fact that all moral problems are solvable via agreement by ethicists. There is -- at all time -- a possibility of contentions when moral issues are being discussed. Also, there is always a possibility of intense disagreement by people in both theory and practice. Nevertheless, if there is a reason to avert problems of controversies in moral dilemmas, to defend the profession of medical ethics, and expertise of ethicists and their professional integrity, a resolution may begin or may be facilitated by the various ways and means discussed so far.
Summary

It is revealed that the growth of bioethics gives rise to quiet a long list of professionals either in medicine, sciences or allied disciplines who lay claim to the title of an ethicist and moral expert. There are hordes of moral problems in daily medical practices expected to be resolved by those qualified to do so. While some people argue that moral quandaries are the domain of ethicists or ethics experts, others argue that no one has the requisite skills for dealing with moral problems, because objective truth is not feasible in ethics, and moral judgment is relative to cultures, beliefs and values.

Who then, are those capable of providing moral reflections on huge intricate moral problems accentuated by advances in medical and biotechnologies from the 20th century? Do we need medical ethicists in medical ethics debates and Medical Ethics Committees more than other professionals to tackle moral problems of our time? Are professional medical ethicists better qualified to make sound ethical decisions than anyone else? Are various Medical Ethics Committees not better off without an expert medical ethicist? Of what use can we put an expert medical ethicist’s expertise?

In this thesis, I took an exploration into the desirability of including a professional medical ethicist in Medical Ethics Committees at the institutional level such as: the Health Ethics Committees (HECs), Research Ethics Committees (RECs), and the Institutional Review Boards (IRBs). In addition to this, I examined a medical ethicist’s desirability as a consultant and expert in medical ethics debates. I supported this argument with two different extremes of theoretical expositions on morality by both Aristotle and MacNaughton, in order to explicate medical ethicist’s functions, roles and relevance in the debates on ethical issues. My argument for ethicist’s desirability is premised on his/her skills and knowledge in philosophical inquiry which are quite useful in critical assessment of moral problems, and these kinds of expertise of an ethicist are easily demarcated from individual reason, and are far from being common to everyone.

Also, professional persona of an ethicist was explained based on the nature of authority and expertise he/she possessed. The authority of a medical ethicist was elucidated via two models. The first model is called medical model, this is unpopular because of its limited scope, where only health workers are imagined or perceived to be medical ethicists. Based on this myopic view of the medical model, the second model that is called a feeder discipline model that gave a comprehensive account of an ethicist was accepted. The acceptance is based on the explanation that a medical ethicist is not only knowledgeable in health care, but acquires skills
and knowledge in other allied disciplines relevant for dealing thoroughly with moral problems.

As a result of this, efforts were put in motion to highlight certain distinctive traits of an ethicist. Some of these elements are: knowledge of philosophical problems, questions, positions and theories (e.g. ethical theories, theories of knowledge, views about human nature and society), knowledge of assumptions, consequences and criticisms of different positions or views, knowledge of types of argument and likely problems (e.g., fallacies like false dichotomy or ambiguities of scope). In addition to this, it is believed that specifically, a medical ethicist high points include mastery of historical, theoretical and methodological underpinnings of bioethics, command of academic literature, rigorous training in ethical reflection, analysis and argumentation.

Certain limits of expert’s competence were elucidated. In other words, it was revealed that experts are useful in facilitating reflection on moral issues; he/she gives advice and makes recommendations which may assist policy makers and individuals. An ethics expert is not a legislator or a justice in moral problems and neither does his/her advice and recommendation binding or obligatory. He/she only gives moral light and direction that may guide parties affected to make their choices, after critical examination of all possible alternatives. A medical ethicist provides an ample chance for committees, individuals and physicians to reflect on the implications of their decisions, and for them to weigh other available alternatives.

In the thesis, I equally made normative proposals for medical ethicist’s inclusion in Medical Ethics Committees, I justified his/her expertise as a consultant and expert in moral dissection on issues bothering medicine and research in medicine. I put an ethicist forward for these positions based on the similarities that exist between him/her and other professionals such as football coaches, doctors, builders and structural engineers among others. The role of an ethicist is favorably compared to those of these professionals in question, and as such, I debunked a claim that negates ethicist’s professional competence.

It was contended that a medical ethicist role could only be justified provided the profession seeks ways and means of averting noticeable shortcomings that are pervasive among professional ethicists themselves, and those lapses that critics of the profession usually put forward to denounce expert knowledge. This, it was argued is a future task for the members within the profession to secure permanent future for the profession and guard the profession’s integrity and status.
Besides, medical ethicists were admonished to strive for meeting standards of a profession to guarantee their profession’s continuous recognition. Some of these standards are: specialized knowledge acquisition, specific training period, service orientation, professional autonomy, professional dominance, a vocation or calling, and a professional mystique. It was suggested that a Guild of Professional Medical Ethicists be established to develop a Medical Ethics curriculum, work out standard criteria for the discipline which current and future members are supposed to conform to.

In the same vein, all medical ethicists were advised to work towards, at least, minimal consensus on volatile ethical issues in medicine, protect objective judgments of other members, and defend normative claims made by members on diverse cases they were charged to deliberate upon. Some of the means towards consensus on moral disagreements that might be employed by ethicists are: obtaining objective information; providing definitional clarity; adopting a professional code; using examples and counter examples; and analyzing different competing arguments.

Lastly, it ought to be emphasized that I did not suggest that ethicists have exclusive expertise, that is, sole rights to determine every issue in medical ethics, rather I spoke on the fact that we may not rule out such expertise in dealing with moral issues. Also, while it is possible to resolve moral disagreements through the means discussed, solutions to others may be elusive. Nevertheless, moves towards resolution in contentious issues through all the means highlighted are quiet relevant and necessary.

It is pertinent to add that whatever argument against medical ethics experts, their contribution is necessary, though they may not be indispensable. This is more so, because according to Verweij et al. (2000), in difficult moral choices, it is prudent to request the service of experts to formulate a prudent report and organize a fruitful discussion. Besides, experts help agents to face difficult moral problems by virtue of their experience, prudence, expertise, and moral sensibility.
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